**Insurance Verification Form**

| | | |
|---|---|---|
| Today's Date: | Appointment Date: | Employee's Initials: |
| Rep's Name: | Patient's Name: | Patient's DOB: |

**Subscriber's Information:**

| | | |
|---|---|---|
| Last Name: | First Name: | Relationship to Patient: |
| Subs DOB: | SSN: | Member ID: |

**Carrier Info:**

| | | |
|---|---|---|
| Insurance Name: | | |
| Claims Mailing Address: | | |
| City: | State: | Zip Code: |
| Insurance Number: | Payor ID: | |

**Fee Schedule: _____ In Network / Out of Network.** **Accept Assignment of benefits: Yes / No** **Coordination of Benefits: _____**

**Plan Info:** **Contract/Calendar: _____**

| | | |
|---|---|---|
| Group Name: | Group Number: | Effective Date: |
| Individual Maximum: | **Maximum Used:** | **Maximum Remaining:** |
| Individual Deductible: | Deductible Remaining: | |
| **Deductible Applies to**: All _____ | Diagnostic/ Preventative_____ | Basic_____ Major_____ |

**Diagnostic/Preventative Services:**

Exam D0150/D0120: _____%_____Freq
Prophy D1110/D1120: _____%_____Freq
Fluoride D1208:_____% _____Freq _____ Age Limit
Sealants D1351:_____% _____Freq _____ Age Limit
Teeth Covered: _____
Limited Exam D0140: _____%_____Freq
**Limited share frequency with other exams**: Yes / No

FMX D0210:_____% _____Freq
PA's D0220/D0230:_____%_____Freq
Bitewings D0274:_____%_____Freq

**Exam History**:_____
_____
**Prophy History:** _____
**Fluoride History:** _____
**Xray History**:_____
_____
**Sealant History:** _____

**Basic Services:**

Perio Maint D4910: _____% _____Freq
**Share Freq with Prophy: Yes / No**
SRP's D4341: _____% _____Freq
Quads Per day:_____
Arestin D4381: Yes / No
**SRP Same Day as Prophy/Perio Maint: Yes / No**
Time between SRP and Prophy Perio Maint:_____

Restorative/Fillings: D2330,D2331,D2393,D2394
_____% _____Freq
**Downgrade**? Yes / No
Simple Ext D7140: _____%
Surgical Ext D7240: _____%
Endo RCT D3330: _____%

**Filling History**: _____
_____
**SRP History:**_____
_____
**EXT History**:_____
_____

**Major Services:**

Crowns D2740: _____% _____Freq Age Limit: _____
**Downgrade? Yes / No** Which Teeth: _____
**PAY ON SEAT / PREP**
Build up D2950: _____% _____Freq
Post and Core D2954: _____% _____Freq
Dentures D5110, D5221,D5213: _____% _____Freq
Implants D6010: Yes / No
OCC Guards D9945,D9944: ____% _____ Freq Limitations if any: _____
**Ortho Coverage: Yes / No _____% Age Limit: _____ Lifetime Max: _____**

**Crown History**: _____
_____
**Bridge History**: _____
**Build Up History**:_____
_____
**Post & Core History**:_____
**Denture History:** _____

**Previous Extractions Covered?** Yes / No **WAITING PERIODS: Basic: Yes / No _____ Major: Yes / No _____**

**SRP'S:** BASIC / MAJOR **SIMPLE EXT:** BASIC / MAJOR **SURGICAL EXT**: BASIC / MAJOR **ENDO:** BASIC / MAJOR