Dental Insurance Verification Form

Complete before the visit. File with the patient record.

PRACTICE NAME

CHART NUMBER

1 · PATIENT AND SUBSCRIBER

PATIENT NAME

PATIENT DATE OF BIRTH

RELATIONSHIP TO SUBSCRIBER

☐ Self ☐ Spouse ☐ Child ☐ Other

SUBSCRIBER NAME

SUBSCRIBER DATE OF BIRTH

MEMBER ID

APPOINTMENT DATE

2 · PLAN AND GROUP

INSURANCE COMPANY (PAYER)

PAYER PHONE

EMPLOYER OR GROUP NAME

GROUP NUMBER

PAYER ID / CLAIMS ADDRESS

IN NETWORK

☐ Yes ☐ No

PLAN TYPE

☐ PPO ☐ HMO / DHMO ☐ Indemnity ☐ Other

OTHER COVERAGE (COB)

☐ None ☐ This plan is primary ☐ This plan is secondary

3 · EFFECTIVE DATES

EFFECTIVE DATE

END DATE

PLAN YEAR

☐ Calendar year ☐ Benefit year starts ___

4 · WAITING PERIODS

BASIC

MAJOR

5–6 · MAXIMUM AND DEDUCTIBLE

ANNUAL MAXIMUM

USED / REMAINING

DEDUCTIBLE: INDIVIDUAL / FAMILY

DEDUCTIBLE MET

DEDUCTIBLE APPLIES TO

☐ Preventive ☐ Basic ☐ Major

ORTHO: COVERAGE / LIFETIME MAX

ORTHO AGE LIMIT

7 · COVERAGE BY CATEGORY

CATEGORY	PLAN PAYS	CATEGORY	PLAN PAYS
Preventive		Endodontics	
Basic		Periodontics	
Major		Oral surgery	

8, 11 · FREQUENCIES AND HISTORY

SERVICE	PLAN LIMIT	LAST DATE	AGE LIMIT
Periodic exam D0120			
Comprehensive exam D0150			
Cleaning, adult / child D1110 / D1120			
Perio maintenance D4910			
Bitewings D0274			
Full series / panoramic D0210 / D0330			
Fluoride D1206 / D1208			
Sealants D1351			

CY: calendar year · mo: months

SCALING AND ROOT PLANING, LAST DATE BY QUADRANT

9–10 · MISSING TOOTH CLAUSE AND DOWNGRADES

MISSING TOOTH CLAUSE

☐ Yes ☐ No

COMPOSITE PAID AS AMALGAM

☐ Yes ☐ No

OTHER DOWNGRADES

REPLACEMENT LIMIT: CROWNS, BRIDGES, DENTURES

12 · PRE-AUTHORIZATION

REQUIRED BEFORE TREATMENT FOR

☐ Crowns ☐ Perio ☐ Implants ☐ Ortho ☐ Other

PREDETERMINATION SENT

13 · CALL REFERENCE

CHECKED BY

☐ Portal ☐ Phone ☐ Real-time eligibility

REPRESENTATIVE

REFERENCE NUMBER

DATE AND TIME

VERIFIED BY (INITIALS)

NOTES