Dental Insurance
Eligibility & Benefits Verification

Appt. Date/Time:

Date: _____ Patient: _____ DOB _____

Subscriber Name: _____ DOB _____ SSN# _____

Primary ☐ Secondary ☐ Payor ID # _____ Ins Carrier Ph: _____

Insurance Carrier: _____ ID# _____

Insurance Carrier Address: _____

Group Plan: _____ Group # _____

Ind. Deductible $ _____ Family Deductible $ _____ Maximum $ _____

Deductible Used $ _____ Maximum Used $ _____

Calendar Year: _____ Effective Date: _____

Procedures	**Percent**	**Deductible**	**Waiting Period**	
Diag/Prev.	_____ %	$ _____	_____	Amalgam Allowance ☐
Basic/Res.	_____ %	$ _____	_____	Occlusal Guard ☐ _____ %
Endo	_____ %	$ _____	_____	Missing Tooth Clause ☐
Periodontics	_____ %	$ _____	_____	Implant Coverage ☐
Oral Surgery	_____ %	$ _____	_____	Ortho _____% age _____
Major	_____ %	$ _____	_____	Ortho Max $_____

Crown/Bridges/Proth Replacement: _____

	Frequency	**Last Date of Service**		**Frequency**	**Last Date of Service**
Prophy	_____	_____	Fluoride	_____	_____
Exam	_____	_____	Quad Scale	_____	_____
BWX	_____	_____	Perio Mtn	_____	_____
Pano/FMX	_____	_____	Arestin D4381 ☐	_____ %	
Sealants	_____	_____	Debridement D4355 ☐	_____%	
			D4346 Scaling with Inflammation	_____%	

Policy Limitations: _____