Insurance Verification Phone Form

Team Member:_____

Subscriber: _____ DOB: _____

Insurance Company:_____

Agent name: _____

Group #: _____

Subscriber ID #:_____

Effective Date:_____

Benefit Year: *circle one* (calendar / some month: _____)

Contracted Allowed Fee Schedule:_____

Patient Portion Calculation *(check one)*

- ⬜ UCR (Category %)
- ⬜ Discount Plan
- ⬜ Copay fee schedule (PPO Copay): _____
- ⬜ Percentages (PPO %)
  - Routine Preventative: %_____
  - Diagnostic /Exams %_____
  - X-rays (if different): %_____
  - Basic: Restorative: %_____
  - Endo: %_____
  - Perio: %_____
  - Oral Surgery: %_____
  - Major: Crowns/Prosthodontics %_____
  - Implant(D6010 , D6057 , D6058) %_____
    (Implant, Abutment, Crown)

Name: *(list all covered on plan)*	Deductible met already: $	Insurance used already:
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$

Frequencies of Services:

BW's : _____

Exams: _____

Fluoride to age & Frequency: _____/_____

Sealants covered to age (D1351): _____

Maximums and Deductibles:

Yearly Maximum: $_____

Individual/Family Deductible: $ _____/_____

Preventive Deductible: $ _____

Other

Waiting Periods (in yrs):Basic_____ Major_____

Replacement Clause (in yrs): Crowns_____ Bridges_____ Dentures_____ Fillings_____

Missing Tooth Clause: ⬜Yes ⬜No

Posterior composites covered **FOR CHILDREN**?: ⬜ Yes or ⬜ No

Posterior composites covered **FOR ADULTS**? : ⬜ Yes or ⬜ No