Insurance Verification

Insurance Name:	Date:
Insured Name:	Patient Name:
Insured DOB:	Patient DOB:
Insured ID/ SS #:	
Employer Name:	
Effective Date:	Fiscal Year:
Yearly Max: $	Maximum Used: $
Yearly Deductible: $	Group #:
Yearly Deductible applies to:	Payor ID #:
Preventive (PREVENTIVE INCLUDES)	
Basic (BASIC INCLUDES)	
Major (MAJOR INCLUDES)	
Implant Coverage:	
Ortho Coverage:	
Last FMS / Pano on file:	FMS/Pano Frequency:
Last Bitewings on File:	Bitewing Frequency:
Coverage for posterior composite:	
Missing tooth clause:	Waiting period:
Repalcement of Crowns; Denture; Bridges:	

Frequency	
Core Build up (D2950)	Adolescent Ortho (D8080)
Osseous Surg (D4260)	Adult Ortho (D8090)
Gum TX (D4341)	Nitrous (D9230)
Arestin (D4381)	Theraeutic drug (D9610)
Perio Maint (D4910)	Desensitizing Agent (D9910)
	Night Guard (D9940)

Insurance #:

Insurance Address:

Notes: _____