INSURANCE ELIGIBILTY AND VERIFICATION

PATIENT INFORMATION

PATIENT NAME: _____ PATIENT DOB: _____

PATIENT SSN: _____ PATIENT PHONE: _____

EMPLOYER NAME/PHONE: _____

EMPLOYER ADDRESS: _____

INSURANCE NAME/PHONE: _____

GROUP #: _____ SUBSCRIBER NAME: _____

SUBSCRIBER SSN: _____ SUBSCRIBER DOB: _____

RELATIONSHIP TO PATIENT: _____

PATIENT PORTION PLEASE FILL

PERCENTAGE BREAKDOWN

EFFECTIVE DATE: _____ TYPE OF YEAR (C/F): _____ FEE SCHEDULE: _____

MAXIMUM: _____ DEDUCTIBLE: _____ FAM. DED: _____

PREV: _____ BASIC: _____ MAJOR: _____

ENDO: _____% PERIO: _____% ORAL SURG: _____% CROWNS: _____%

SEALANTS: _____% AGE LIMIT: _____ PM INCLUDED: _____ FREQ: _____

POSTERIOR COMPOSITE COVERAGE: _____

CHEMOTHERAPUTICS: _____% AND FREQ: _____

LAST FMS/PANO: _____ AMT SPENT FROM MAX: _____

PAST TX HX: _____

FOR OFFICE USE ONLY

FREQUENCIES

COMPREHENSIVE EXAM: _____ PERIODIC EXAM: _____

FMS/PANO: _____ BITEWINGS: _____ PROPHY: _____

4341 (ROOT PLANING): _____ 4910 (PERIO MAIN): _____

INSURANCE RULES/STIPULATIONS

REPLACEMENT RULES:

CROWNS _____ BRIDGES _____ DENTURES/PARTIALS _____

MISSING TOOTH CLAUSE (Y/N): _____

PRE-DETERMINATION REQUIRED (Y/N):

4341 (R/P): _____ CROWNS: _____

NOTES: