Patient Insurance Verification

Pt. Name			DOB:		
Relationship to Sub.	Subscriber Name		DOB:		
Subscriber ID # OR SS#	Group #	Employer			
Ins Name	Ins. Phone	Rep Name			
Ins. Address		City			
State	Zip	Payer ID	In Network ☐Yes ☐No		
Effective Date	Annual Max	Individual Ded.	Ded. Met ☐Yes ☐No		
Family Ded	Family Ded. Met ☐Yes ☐No	Ded Waived on Prev. ☐Yes ☐No	Benefits remaining $		
Contract Year	Calendar Year	Waiting Periods ☐Yes ☐No	Basic		
		Major	Prosthetic		
Sealants Coverage	How often	Up to Age			
Fluoride	How often	Up to Age			
Missing tooth Clause ☐Yes ☐No	Covered ☐Yes ☐No	Prosthetic			
Prev.	Basic	Perio	Endo	Major	Pros.
Posterior Composites Covered ☐Yes ☐No	Downgraded to Amalgam ☐Yes ☐No				
Pre-Auth Required ☐Yes ☐No $	Night Guard(D9940) ☐Yes ☐No	Reason %			
Cleaning :	Fmx	Bitewings	Exams /		
D4355 coverage ☐Yes ☐No	SRP	other			
History	Exam	FMX	Cleaning	Bitewings	
crowns	Partial/ Denture	Fluoride			
Other Insurance Coverage					
Verified by	Date Verified				