Insurance Benefit Information

Verified by: _____

PATIENT NAME: _____ **DOB**: _____

Subscriber Information:

Name: _____ DOB: _____ Subs. ID#: _____

Relationship to Patient: _____Self _____Child _____Other Subs SS#: _____

Insurance Company Name: _____ Phone: _____

Group Name: _____ Group #: _____ Payor ID: _____

Effective Date: _____ Benefit Year: _____ Calendar _____Month

Other Insurance: _____, If yes: Insurance Name: _____

Subscribers Name: _____ ID # _____ DOB: _____

Benefits:

Agent Name/Ref: _____ Yearly Maximum: _____

Calendar/Contract Year: _____ to _____ Benefits Remaining: _____

Waiting Period: _____ Basic / _____Major Downgrade Posterior composites: _____

Missing Tooth Clause: _____ Replacement Clause: Fillings: _____ Crowns: _____

Ind Deductible: _____ / Family Deductible: _____

Routine Preventative: _____ %	Basic: Restorative: _____%	Major: _____%
Diagnostic/Exams: _____%	Endodontics: _____%	D2929: _____% /Freq: _____
X-Rays: _____%	Periodontics: _____%	D2930: _____%/Freq: _____
Consultation (D9310): _____%	Oral Surgery: _____%	D2934 _____%/Freq: _____
Limited Exam (D0140): _____% Frequency: _____ Does it share frequency? _____		

Frequencies of Service:

Bitewings: (D0272/D0274) _____ **Pano:** (D0330) _____ **PA's:** (D0220/D0230) _____

Exams: (D0150/D0120) _____ **Prophy:** (D1110/D1120) _____ Age: _____ (child) _____(adult) **Fluoride:** (D1206) _____ Age: _____

SDF(D1354):_____% Age: _____ Frequency: _____ **NO2:** (D9230) _____% / Age: ____

Space Maintainer (D1510) _____% / Age: _____ Frequency: _____

Sealants: (D1351) _____% Age: _____ Frequency: _____ Teeth #: _____ Need to be Carie Free? _____

Additional Notes: _____ Other Family Members: _____