DENTAL INSURANCE VERIFICATION FORM

The Privacy Act prevents us from getting certain information from your insurance company.

You must supply us with the additional information we need if you wish us to bill your insurance directly.

1. Recall frequency and units of scale allowed.
2. Annual Maximums and percentages for Basic and Major treatment.
3. Benefit year is different from a calendar year.

If you have a policy book, please bring to your appointment and we can extract the information that we need.

Please be reminded that your insurance is a contract between your insurance company and yourself <u>NOT</u> the dental office. We will do our best to help you keep track of your maximum and frequencies, but it is ultimately your responsibility to know your insurance limits. We are happy to help you with any questions.

Patient Information

Name: _____ Date of Birth: _____

Relationship to Subscriber: _____

Primary Insurance

Name: _____ Date of birth: _____

Insurance Company: _____ Employer: _____

Policy #: _____ Certificate #: _____

Secondary Insurance

Name: _____ Date of birth: _____

Insurance Company: _____ Employer: _____

Policy #: _____ Certificate #: _____

Coverage Information

Primary

Maximum: _____ Separate or combined

Benefit Period: _____

Deductible: _____

Basic %: _____ Major %: _____

Recall/BW Frequency: _____

Scale Units: _____ Fluoride: _____ (age limit?)

Secondary

Maximum: _____ Separate or Combined

Benefit Period: _____

Deductible: _____

Basic%: _____ Major %: _____

Recall/BW Frequency: _____

Scale Units: _____Fluoride_____ (age limit?)