INSURANCE VERIFICATION

Patient:		**Insured:**	
DOB:		**DOB:**	
Coverage Type:		**SS:**	
Employer:		**Subscriber ID:**	
Insurance Company:		**Policy Effective Date:**	
Claims Address:		**Group:**	
Payor ID:		**Phone:**	

Calender / Plan Year	**From: To:**	**Used to Date:**	
Deductible:	**Ind$ Fam$**	**Annual Max:**	**Ind$ Fam$**

Ortho Coverage:	**Yes / No**	**Ortho Max:**	**%**

Waiting Period?	**Yes / No**	**Missing Tooth Clause?**	**Yes / No**

Types:	Deductible Applies?	Types:	Date of Last:
PREV %	**Yes / No**	**Comp D0150**	
DIAG %	**Yes / No**	**Periodic D0120**	
BASIC %	**Yes / No**	**Limited D0140**	
MAJOR %	**Yes / No**	**Bitewing**	
ENDO %		**Prophy**	
ORAL %		**FMX/PAN %**	
PERIO %		**PA X-ray %**	**NA**
Downgrade to Amalgam? Y / N	**%**	**SRP D4341 Freq:**	**%**
Single Crowns D2740 Prep/Insert Freq:	**%**	**Waiting Period between SRP and Perio**	**Y / N**
Occl Guard D9944 Freq:	**%**	**Perio Maintenance D4910 Freq:**	**%**
Pallative D9110	**%**	**Debridement D4355 Freq:**	**%**
Implants D6010	**%**	**Build-ups D2950**	**%**
Abutments D6057	**%**	**Prefab P/C D2954**	**%**
Implant Crowns D6058	**%**		