DENTAL INSURANCE VERIFICATION FORM

Patient Information:

Patient Name: _____
Gender: ☐ Male ☐ Female ☐ Prefer to self-describe: _____
Date of Birth: _____
Address: _____
Social Security Number: _____
Phone: _____ Email: _____

Patient Insurance Information:

Insurance Provider: _____ Policy Number: _____ Group Number: _____
Insurance Provider Phone Number: _____
Subscriber Name: _____ Date of Birth: _____
Subscriber Phone: _____
Subscriber's Relationship to Patient: _____

Insurance Verification:

Is dental insurance coverage active? ☐ Yes ☐ No

Begin Date: _____ End Date: _____

Type of Insurance Plan: ☐ DMHO ☐ PPO ☐ Indemnity Plan ☐ Discount Plan ☐ Other: _____

Coverage Details for Specific Dental Services:

Routine Exams and Cleanings: ☐ Covered ☐ Not Covered
Diagnostic X-rays: ☐ Covered ☐ Not Covered
Fillings and Sealants: ☐ Covered ☐ Not Covered
Root Canal Treatment: ☐ Covered ☐ Not Covered
Orthodontics (braces, aligners): ☐ Covered ☐ Not Covered
Periodontics (gum treatment): ☐ Covered ☐ Not Covered
Prosthodontics (crowns, bridges, dentures): ☐ Covered ☐ Not Covered
Oral Surgery (extractions, implants): ☐ Covered ☐ Not Covered

Pre-Authorization Requirements: ☐ Required for some services ☐ Not required

Deductibles and Copayments:

Deductible Amount: $_____

Copayment for Dental Visit: $_____
Deductible Met to Date: $_____
Annual Out-of-Pocket Maximum: $_____
Exclusions and Limitations: _____

Referral Requirements for Specialist Visits: ☐ Required ☐ Not Required

Coverage for Network and Out-of-Network Services:

In-Network: ☐ Covered ☐ Not Covered
Out-of-Network: ☐ Covered ☐ Not Covered

Contact Information for Further Inquiries:

Contact Person Name: _____
Phone: _____ Email :_____

Additional Notes:
_____
_____
_____

Date Verified: _____ Verified by: _____