Insurance Verification

Patient Name: DOB:

Patient SSN: Reason for Visit:

**Dental Primary**

Ins Company Sub:

 Address: Phone:

 DOB: ID #:

 Group #:

 Traditional // PPO // Premier Preferred Provider

Which Network Effective Date Calendar Year No? Explain Waiting Period Eligible YES NO

Deductible \_ Met \_ Max $ Used $ Avail $ Pend $

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **IMPLANT** | **DESCRIPTION** | **% COV** | **Notes** |  |
| D4263 | Bone Repl. Graft, First Site Quad |  |  |  |
| D4265 | Particulate Bone |  |  |  |
| D4266 | Membrane |  |  |  |
| D4267 | Non-Resorb Mem |  |  |  |
| D6010 | Implant |  |  |  |
| D7951 | Sinus Lift |  |  |  |
| D7950 | Ridge Aug |  |  |  |
| D7953 | Socket Pres BG |  |  |  |
| D5851 | Essix Retainer |  |  |  |
| D6793 | Temp Crown |  |  |  |
| **DENTAL** | **DESCRIPTION** | **% COV** | **Notes** |  |
| D7140 | Simple Ext |  |  |  |
| D7210 | Surg. Removal |  |  |  |
| D7220 | Soft Tissue |  |  |  |
| D7230 | Partial Bony |  |  |  |
| D7240 | Full Bony |  |  |  |
| D7251 | Coronectomy |  |  |  |
| D7280 | Uncover/Ortho |  |  |  |
| D7283 | Place Dev/Ortho |  |  |  |
| **ANESTHESIA** | **TYPE** | **% COV** | **Notes** |  |
| D9223 | General |  |  |  |
| D9230 | Nitrous |  |  |  |
| D9248 | Oral |  |  |  |
| D9613 | Injection |  |  |  |
| **VISIT TYPE** | **DESCRIPTION** | **% COV** | **Frequency** | **# Used** | **Date** |  |
| D0150 | Comp. Exam |  |  |  |  |  |
| D0330 | Pano |  |  |  |  |  |
| D0367 | Cone Beam-CT |  |  |  |  |  |
| D6190 | X-Nav/Trios |  |  |  |  |  |
| D9310 | Consult |  |  |  |  |  |
| D0140 | Problem Focus |  |  |  |  |  |

Prev Basic Major

Bill Medical first: YES NO Tooth Missing: YES NO Clause/Guidelines: YES NO

**Call Log**

Date Initials Notes

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Date Initials Notes