Insurance Checklist

Patient's Name_____Date of Birth_____
Guarantor Name_____Date of Birth_____
Guarantor's SS#_____
Relationship to Patient: Self_____ Spouse_____ Child_____ Other_____
Member #_____ Group#_____
Employer:_____

Name of Dental Benefits Plan_____Effective Date_____
Phone Number_____Contact_____
Mailing Address_____
_____
_____

Term of Coverage: Calendar Year_____ Benefit Year_____
Birthday Rule? Yes_____ No_____

Yearly Limitation_____ Amount Remaining_____
Family Limitation?_____ Amount Remaining_____
Personal Limitation?_____ Amount Remaining_____
Family Deductible?_____ Amount Remaining_____
Personal Deductible?_____ Amount Remaining_____

Benefits Available:

Preventative_____% Routine Restorative_____%
Sealants_____% Periodontal Treatment_____%
Fixed & Removable Prosthetics_____% Oral Surgery_____%
Orthodontics_____% Implants_____%

Restrictions and Procedure Limitations:

Waiting period for any services? Yes_____No_____

Claim Submission:

ECF/Payor ID_____Paper Claims_____
ECF: Radiographs under separate cover?_____ Scanner required?_____

Claim Form:

Generic ADA form?_____ Insurer form?_____

Is there secondary insurance? Yes_____No_____If Yes, please complete the following:

Employer:_____Group#_____
Name of Dental Benefits Plan_____Effective Date_____
Mailing Address:_____
_____
_____
Insured's SS#_____Insured's Date of Birth:_____
Relationship to Patient: Self_____Spouse_____Child_____Other_____