Grosso Family Dentistry

DENTAL INSURANCE VERIFICATION FORM

Use this form as a template for documenting dental benefits when calling Member Services for insurance information

PATIENT INFORMATION

Patient Name: _____ Birthdate: _____

Relationship to Subscriber: _____

SUBSCRIBER INFORMATION

Subscriber Name: _____ Subscriber Birthdate: _____

Subscriber Address: _____

ID Number: _____ Group Number: _____

Employer Name: _____

INSURANCE INFORMATION

Insurance Company: _____

Claims Address: _____

Phone Number: _____ Payor ID Number: _____

Effective Date: _____ Renewal Month: _____

Yearly Maximum: _____ Deductible per Individual: _____

Deductible Applies to: ☐ Preventative ☐ Basic ☐ Major

Waiting Period: **Y** or **N** Details: _____ Missing Tooth Clause: **Y** or **N**

DENTAL BENEFITS

Preventative: _____% Fluoride Frequency: _____ Fluoride Age Limit: _____

Basic: _____% Downgrade Posterior Composites: **Y** or **N**

Major: _____% Implants Covered: **Y** or **N**

Orthodontics: _____% Maximum: $_____ Deductible: $_____ Age Limit: _____

Miscellaneous: Replacement Clause: _____ yrs Nightguard Coverage (D9940): **Y** or **N**

Notes: _____

Disclaimer: This is a summary of plan benefits and is not intended to be a contract. Actual coverage will be determined when the claim is processed. This is not a dental pre-determination of benefits or a guarantee of payment.