Dental Insurance Information Required

Patient and Birthdate: _____

Insured Person and Birthdate: _____

Employer: _____

Employer's address and phone number: _____

Effective date of insurance coverage: _____

Insurance carrier: _____

Group/Policy Number: _____

ID/Employee/Cert Number: _____

Dependent Number: _____

Percentage of coverage: Basic: _____ Major: _____ Ortho: _____

Deductible: _____

Annual financial Limit: _____

Calendar or Rolling Year: _____

Bill direct or reimbursement plan: _____

Employee signature required: _____

Dual coverage allowable: _____

Authorized employer signature required: _____

EDI/ Itrans transmission possible: _____

Recall Limit: _____

Scaling/root planning maximum: _____

Composite Restoration on molar teeth: _____

Fissure sealants covered on children/adults: _____

Is this plan covered by the current fee guide: _____

What is the re-submission time frame allowed: _____

SUBMIT