INSURANCE VERIFICATION

Date: _____ Initials:_____ Ins Rep Name: _____

Call Ref#_____

HAVE THIS INFO READY WHEN YOU CALL:

Patient Name: _____ DOB: _____

Policy Holder Name: _____ DOB: _____

SS/ID: _____

Relationship to Patient: ☐Self ☐ Spouse ☐ Dependent ☐Other _____(Step-parent/Grandparent)

Place of Employment: _____

GET INFO:

Group Name: _____ Group #: _____

Do they want us to file with SS# or ID#? _____ SS / ID#:_____

BENEFIT INFO:

Active Ortho Coverage ☐ Yes ☐ No Effective Date: _____

Waiting Period: ☐ Yes ☐ No Waiting Over on _____ Date (If Applicable)

Covers "Work in progress": ☐ Yes ☐ No Age Limit: _____ Yrs or ☐ No Age Limit

Plan Covers: ☐ Member only ☐ Dependents ☐ Member& Spouse ☐ Member, Spouse & Dependents

MAXIMUM AND DEDUCTIBLES:

Ortho Max: _____ ☐ Lifetime ☐ Annual ☐ No Max Notes: _____

Annual Dental Max: _____ ☐ Combined Benefits ☐ Not Combined

Ortho Benefits used to date:_____ Deductible: _____☐ Lifetime ☐ Annual

Benefits Paid: ☐ 50% ☐ 80% ☐ 100% ☐ _____%

Initial Payment Paid: _____ % of Allowed Amount / Expected total benefit.

Paid: ☐ Automatically ☐ Claim Submission

☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Coordination of Benefits: ☐ None ☐ Birthday Rule ☐ Non-Duplicating ☐ Standard

GET INFO:

Insurance Company: _____

Claims Address: _____ Phone: _____

_____

Payer ID: _____

Fax Claims to: _____ Claims cannot be faxed ☐

NOTES:_____

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