INSURANCE VERIFICATION SERVICES



DEFINITIONS:

EXPANDED VERIFICATION & ELIGIBILITY: Includes eligibility status, deductible, maximum & remaining benefits for all restorative appointments. Includes eligibility plus breakdown of coinsurance percentages, frequency limitations, history and up to 8 custom service codes/inquiries for all scheduled hygiene/new patients. Completed verification form emailed to the office.

EXPANDED VERIFICATION W/ DATA ENTRY: The Expanded Verification & Eligibility with data entry directly into the patient's chart & verification form scanned into patient chart.

RUSH (LESS THAN 48HRS): Any verification request made by the office with less than 48 business day hours notice.

PLAN OPTIONS:

- AUTOMATICALLY PROCESS ALL PATIENTS ON SCHEDULE AS OUTLINED ABOVE
- PROCESS ONLY NEW PATIENTS & EXISTING PATIENTS NOT SEEN WITHIN 6 OR 12 MONTHS (YOU CHOOSE THE EXISTING PATIENT LAST VISIT PARAMETER)
- ONLY PROCESS PATIENTS REQUESTED BY OFFICE

All verifications are completed within 48hrs (business day hours).

Rush requests should be emailed to the account specialist assigned to your office with the subject line: URGENT VERIFICATION REQUESTED. The office will receive an email notification within 2 hours if the request can be accommodated or not.

Invoices are billed on the 1st of each month for all verification services completed the previous month. Sixty days required to end services. A one time registration fee of \$600.00 is due upon signup (waived for Insurance AR Clients).

The Owl Advantage cannot guarantee insurance coverage for any insurance verification service performed and cannot be held liable for any inaccurate information provided by an insurance company.

INSURANCE COMPANY: GROUP# PH# ADDRESS: NETWORK? □ IN □ OUT FEE SCHEDULE? PAYOR ID# PAYOR ID# EFFECTIVE DATE: BENEFIT PERIOD: □ CALENDAR YR □ BENEFIT PERIOD	EXPANDED INSURANCE VERIFICATION FORM									
NETWORK? O IN O OUT	PATIENT NAME:						DOB:	ID#	SS#	
ADDRESS: NETWORK? □ IN □ OUT FEE SCHEDULE? PAYOR ID# EFFECTIVE DATE: BENEFIT PERIOD: □ CALENDAR YR □ BENEFIT PERIOD ANNUAL MAX: \$ REMAINING: \$ IND. DEDUCTIBLE \$ REMAINING DEDUCTIBLE \$ PERIOD? PREV/DIAG: 96 □ Y □ N □ Y □ N □ Y □ N □ MAJOR: 96 □ Y □ N	SUBSCRIBER NAME:						DOB:	ID#_	SS#	
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FLUORIDE: 2/CY 2/12M 1/6M 1/CY	PA XRAY:%	_% DED APF			LIES? OY ON		NO FREQ			
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HISTORY: PROPHY:EXAM:BWX:FMX/PAN:FLUORIDE: CUSTOM CODES/INQUIRIES: SRP D4341/4342:% FREQ/NOTES? FMD D4355:% FREQ/NOTES? ARESTIN D4381:% FREQ/NOTES? PERIO MAINT D4910:% SHARES FREQ W/ PX? OY ON CROWN D2740:% FREQ/NOTES? DOWNGRADE? OY ON IMPLANT D6010:% FREQ/NOTES? MISSING TOOTH CLAUSE? OY ON BONE GRAFT D7953:% FREQ/NOTES?	FLUORIDE: 0 2/CY		o 2/	/12M	•					
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COMPLETED BY: _____ DATE: _____ METHOD: ONLINE FAX PHONE: REF#_____

