ENDO EXPANDED INSURANCE VERIFICATION FORM

PATIENT NAME: _____ DOB: _____ ID#_____SS#_____

SUBSCRIBER NAME: _____ DOB: _____ ID#_____ SS#_____

INSURANCE COMPANY: _____ GROUP#_____ PH#_____

EMPLOYER/GROUP PLAN NAME:_____

ADDRESS: _____

NETWORK? ▢ IN ▢ OUT FEE SCHEDULE? _____ PAYOR ID#_____

EFFECTIVE DATE: _____ BENEFIT PERIOD: ▢ CALENDAR YR ▢ BENEFIT PERIOD _____

ANNUAL MAX: $_____ REMAINING: $_____ IND. DEDUCTIBLE $_____ REMAINING DEDUCTIBLE $_____

	DEDUCTIBLE APPLIES?	WAITING PERIOD?	
PREV/DIAG:_____%	▢Y ▢N	▢Y ▢N	_____
BASIC:_____%	▢Y ▢N	▢Y ▢N	_____
MAJOR:_____%	▢Y ▢N	▢Y ▢N	_____
ENDO:_____%	▢Y ▢N	▢Y ▢N	_____

		DEDUCTIBLE APPLIES?	WAITING PERIOD?	ELIGIBLE?	
EXAM D0140:	_____%	▢Y ▢N	▢Y ▢N	▢Y ▢N	FREQ:_____HX:_____
CONSULT D9310:	_____%	▢Y ▢N	▢Y ▢N	▢Y ▢N	FREQ:_____HX:_____
PA XRAY D0220/0230:	_____%	▢Y ▢N	▢Y ▢N	▢Y ▢N	FREQ:_____HX:_____
CONE BEAM D0380:	_____%	▢Y ▢N	▢Y ▢N		_____
PULP VITALITY D0460:	_____%	▢Y ▢N	▢Y ▢N		_____
CORE BUILDUP D2950:	_____%	▢Y ▢N	▢Y ▢N		_____
POST & CORE D2954:	_____%	▢Y ▢N	▢Y ▢N		_____
THERAP. D3310-D3330:	_____%	▢Y ▢N	▢Y ▢N		_____
RE-TX D3346-3348:	_____%	▢Y ▢N	▢Y ▢N		_____
APEX D3351-3353:	_____%	▢Y ▢N	▢Y ▢N		_____
APICO. D3410-D3450:	_____%	▢Y ▢N	▢Y ▢N		_____
INC. THERAPY D3332:	_____%	▢Y ▢N	▢Y ▢N		_____
PALLIATIVE D9110:	_____%	▢Y ▢N	▢Y ▢N		_____
NITROUS D9230:	_____%	▢Y ▢N	▢Y ▢N		_____
INT BLEACH D9974:	_____%	▢Y ▢N	▢Y ▢N		_____

NOTES:

COMPLETED BY: _____ DATE: _____

METHOD: ▢ ONLINE ▢ FAX ▢ PHONE: REF#_____

THE OWL ADVANTAGE -dental solutions-
