

GP 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 WAITING
APPLIES? PERIOD?
PREV/DIAG: _____ % ☐ Y ☐ N ☐ Y ☐ N _____
BASIC: _____ % ☐ Y ☐ N ☐ Y ☐ N _____
MAJOR: _____ % ☐ Y ☐ N ☐ Y ☐ N _____
PERIO: _____ % ☐ Y ☐ N ☐ Y ☐ N _____
ENDO: _____ % ☐ Y ☐ N ☐ Y ☐ N _____
ORAL SX: _____ % ☐ Y ☐ N ☐ Y ☐ N _____
PROSTH: _____ % ☐ Y ☐ N ☐ Y ☐ N _____
ORTHO: _____ % ☐ Y ☐ N ☐ Y ☐ N MAX: \$ _____ REM. MAX: \$ _____ UP TO AGE: _____

FREQUENCY/AGE LIMITATIONS:

PROPHY: ☐ 2/CY ☐ 2/12M ☐ 1/6M ☐ _____
EXAM: ☐ 2/CY ☐ 2/12M ☐ 1/6M ☐ _____
BWX: ☐ 2/CY ☐ 2/12M ☐ 1/6M ☐ 1/CY ☐ _____
PA XRAY: _____ % ☐ DED APPLIES? ☐ Y ☐ N FREQ? _____
FMX/PAN: ☐ 1/3Y ☐ 1/5Y ☐ _____
FLUORIDE: ☐ 2/CY ☐ 2/12M ☐ 1/6M ☐ 1/CY ☐ _____ UP TO AGE: _____
SEALANTS: ☐ 1/LIFE ☐ 1/3Y ☐ _____ ☐ PERM UNREST MOLARS _____ % UP TO AGE: _____

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? ☐ Y ☐ N _____
CROWN D2740: _____ % FREQ? _____ DOWNGRADE? ☐ Y ☐ N
IMPLANT D6010: _____ % FREQ/NOTES? _____ MISSING TOOTH CLAUSE? ☐ Y ☐ N
BONE GRAFT D7953: _____ % FREQ/NOTES? _____
OCCLUSAL GUARD D9944: _____ % FREQ/NOTES? _____

COMPLETED BY: _____ DATE: _____
METHOD: ☐ ONLINE ☐ FAX ☐ PHONE: REF# _____

