ORAL SURGERY 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?	ELIGIBLE?
EXAM D0140:	_____%	▢Y ▢N	▢Y ▢N	▢Y ▢N _____
CONE BEAM D0366:	_____%	▢Y ▢N	▢Y ▢N	▢Y ▢N _____
CONSULT D9310:	_____%	▢Y ▢N	▢Y ▢N	▢Y ▢N _____
PANORAMIC D0330:	_____%	▢Y ▢N	▢Y ▢N	▢Y ▢N _____
SIMP EXTS D7140:	_____%	▢Y ▢N	▢Y ▢N	_____
SURG EXTS D7210:	_____%	▢Y ▢N	▢Y ▢N	_____
COMP BONY EXT D7240:	_____%	▢Y ▢N	▢Y ▢N	_____
EXPOSE D7280:	_____%	▢Y ▢N	▢Y ▢N	_____
MOBILIZATION D7282:	_____%	▢Y ▢N	▢Y ▢N	_____
BOND D7283:	_____%	▢Y ▢N	▢Y ▢N	_____
INCISE/DRAIN D7510:	_____%	▢Y ▢N	▢Y ▢N	_____
BONE GRAFT D7953:	_____%	▢Y ▢N	▢Y ▢N	_____
GRAFT W/IMP D6104:	_____%	▢Y ▢N	▢Y ▢N	_____
IMPLANT D6010:	_____%	▢Y ▢N	▢Y ▢N	_____ MTC? ▢Y ▢N

	DEDUCTIBLE APPLIES?	WAITING PERIOD?	
ANESTHESIA D9222/9223:_____%	▢Y ▢N	▢Y ▢N	_____

▢ BY REVIEW/MED NECESSITY ▢ UP TO 1 HOUR PER DAY ▢ ANY ORAL SURGERY PROCEDURE

▢ MIN OF _____ SIMPLE EXTS (D7140)

▢ MIN OF _____ SURGICAL EXTS (D7210/7220/7230/7240/7250)

▢ MIN OF _____ IMPACTED EXTS (D7220/7230/7240)

▢ MIN OF _____ _____ IN DIFFERENT QUADRANTS

▢ MIN OF _____ IMPLANTS

▢ _____

▢ _____

COMPLETED BY: _____ DATE: _____

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

THE OWL ADVANTAGE -dental solutions-

OFFICE NAME | OFFICE ADDRESS | OFFICE PHONE NUMBER

TAX ID# | PROVIDER NAME | NPI# | LIC#

PROVIDER NAME | NPI# | LIC#