PERIO 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	_____
PERIO:_____%	▢Y ▢N	▢Y ▢N	_____
ENDO:_____%	▢Y ▢N	▢Y ▢N	_____
ORAL SX:_____%	▢Y ▢N	▢Y ▢N	_____

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	▢_____	

HISTORY:

PROPHY:_____EXAM:_____BWX:_____FMX/PAN:_____

CUSTOM CODES/INQUIRIES:

GINGIVECTOMY D4210/4211:	_____%	FREQ/NOTES?_____
SRP D4341/4342:	_____%	FREQ/NOTES?_____ 4 QUADS SAME DAY? ▢Y ▢N
FMD D4355:	_____%	FREQ/NOTES?_____
ARESTIN D4381:	_____%	FREQ/NOTES?_____
PERIO MAINT D4910:	_____%	SHARES FREQ W/ PX? ▢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#_____

THE OWL ADVANTAGE -dental solutions-

OFFICE NAME | ADDRESS | PHONE NUMBER

TAX ID# | DOCTOR NAME | NPI# | LIC#