Dental Insurance Benefits Checklist

Date:_____ Rep Name: _____

Patient: _____

Patient's Date of Birth: _____

Relationship to Subscriber:

☐ Self ☐ Spouse ☐ Dependent

Eligibility Date:_____

Maximum benefit: $ _____

☐ Calendar Year ☐ Plan Year (renewal date _____)

Remaining Benefit: $ _____

Deductible: $ _____ Family Deductible: $_____

Applies to: ☐ Prev ☐ Basic ☐ Major

Waiting Period: Prev_____ Basic _____ Major_____

Subscriber:_____

Subscriber Date of Birth: _____

Subscriber ID# (SS or ID#): _____

Employer/Group Name:_____

Insurance Company: _____

Mailing Address:_____

_____

Phone:_____ Fax:_____

Plan Type:

☐ PPO ☐ Traditional ☐ Capitation ☐ Fee schedule

Out-of-Network benefits: ☐ Yes ☐ No

COB: ☐ Standard ☐ Non-dup ☐ Birthday Rule

Summary of Benefits

Preventive _____ % Basic _____% Major_____% Endo _____% Perio_____ % Radiographs _____ %

Occlusal Guards _____% Freq 1 x _____months

SRP Frequency 1 x ____months How many quads of SRP per visit: _____

Sealants _____ % Age limitation____ Freq 1 x _____ months/yrs/lifetime Molars/Premolars Primary/Permanent

Fluoride _____ % Age limitation____ Freq _____

Is there a missing tooth clause (MTC)? _ ☐ Yes ☐ No

Prophylaxis Freq: ☐ 2 x cal yr ☐ 2 x plan yr ☐ 1 x 6 months ☐ 1 x 12 consecutive months

Age limitation: _____

Perio Maintenance Freq: ☐ 2 x cal yr ☐ 2 x plan yr ☐ 1 x 6 months ☐ 1 x 12 consecutive months

Radiograph Frequency: BWX_____ FMX/Pano _____ Periapicals _____

Replacement Clause: Crowns/FPD_____ months/yrs Dentures/Partials_____months/yrs

Implants _____% Freq _____ If no implant coverage, are implant restorations covered? ☐ Yes ☐ No