# DENTAL INSURANCE VERIFICATION FORM

Patient Name: ______________________ Member ID: ______________________

Date of Birth: ______________________ Group Number: ______________________

Subscriber Name (if different): ______________________

Insurance Company: ______________________

Insurance Company Address: ______________________

Insurance Phone Number: ______________________

**Verification Details:**

**1. Eligibility Verification:**

Is the patient currently eligible for dental benefits under this insurance plan? ________ (Yes/No)

**2. Coverage Level:**

Please specify the type of coverage (e.g., Basic, Major, Orthodontic): ____________________________

**3. Co-Payment / Deductible:**

Specify any co-payment or deductible amounts that apply to dental services: ______________________

**4. Annual Maximum Benefit:**

Total annual maximum benefit amount available to the patient: ________________________________

**5. Waiting Periods:**

Are there any waiting periods applicable for specific services? If yes, please describe: ___________

**6. Exclusions and Limitations:**

List any notable exclusions or limitations under this plan: _____________________________________

**7. Pre-Authorization Requirements:**

Are pre-authorizations required for certain procedures? If yes, which procedures? _______________

**8. Claim Submission Address:**

Provide the address or electronic submission method for claims: ________________________________

**9. Plan Contact Person:**

Name and direct phone number or email of the insurance representative verifying this information:

**Authorized Verifier Information:**

Name: ______________________

Title: ______________________

| **INSURANCE VERIFIER'S SIGNATURE** | **DENTAL OFFICE REPRESENTATIVE SIGNATURE** |
| --- | --- |
| Signature: ___________________________ | Signature: ___________________________ |

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