Dental Insurance Verification & Breakdown Form

Complete at least one business day before the appointment. One form per patient, per plan.

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Appointment date _____ Verified by _____ Date verified _____

1 Patient & subscriber

Patient name _____ Patient DOB _____

Subscriber name _____ Subscriber DOB _____

Relationship to subscriber _____ Member ID _____

Group number _____ Employer / plan name _____

2 Plan & eligibility

Insurance company _____ Provider phone _____

Payer ID _____ Claims address _____

Coverage start date _____ Coverage end date _____

Plan active on appointment date? ☐ Yes ☐ No _____ Assignment of benefits accepted? ☐ Yes ☐ No _____

Our provider in-network? ☐ Yes ☐ No _____ Plan type: PPO / DHMO / indemnity / Medicaid _____

3 Maximums & deductible

Annual maximum _____ Remaining this year _____

Benefit year (calendar / plan year) _____ Deductible, individual / family _____

Deductible met so far _____ Ortho lifetime max / remaining _____

Deductible applies to diagnostic and preventive? ☐ Yes ☐ No _____

4 Coverage by category

CATEGORY	COVERED %	WAITING PERIOD	NOTES / LIMITS
Diagnostic / preventive			
Basic / restorative			
Major (crowns, bridges, dentures)			
Periodontics			
Endodontics			
Oral surgery			
Implants			
Orthodontics			

4b Treatment estimate for the patient

CDT CODE	PROCEDURE / TOOTH	FEE	EST. INSURANCE	EST. PATIENT
	Total			

Verification & Breakdown Form, continued

Frequencies, the clauses that cut payment, and the call record.

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5 Frequencies & history

PROCEDURE	ALLOWED (E.G. 2 PER YEAR)	LAST DATE DONE	ELIGIBLE ON APPT DATE?
Periodic exam			
Prophy (cleaning)			
Bitewings			
Full-mouth X-rays / pano			
Fluoride (age limit)			
Sealants (age / teeth)			
Perio maintenance			
SRP (per quadrant)			
Crown replacement			
Denture replacement			

6 Clauses that cut payment

Missing tooth clause? ☐ Yes ☐ No _____

Downgrades (composite / crowns)? ☐ Yes ☐ No _____

Alternate benefit (LEAT) applies? ☐ Yes ☐ No _____

Waiting periods still running? ☐ Yes ☐ No _____

Pre-existing exclusions? ☐ Yes ☐ No _____

Frequency shared with other plans? ☐ Yes ☐ No _____

7 Before you treat

Pre-authorization required? ☐ Yes ☐ No _____

Secondary insurance on file? ☐ Yes ☐ No _____

Primary / secondary (COB rule) _____

X-rays / narrative needed? ☐ Yes ☐ No _____

Timely filing limit _____

Attachment method (e.g. NEA) _____

8 Call or portal record

Portal or phone _____

Call reference # _____

Rep name _____

Date and time _____

9 Notes for the front desk

Why each line matters: "Active" coverage is not enough. Frequencies, waiting periods, the remaining maximum and the missing tooth clause are what decide whether a claim pays and the estimate you give the patient is right. Verifying a day ahead leaves time to fix problems before the patient is in the chair.

Claims still coming back denied?

Get a free 30-minute AR analysis: we show which claims can still be collected and where the denials start.

practicealpha.io/free-ar-analysis