MOORESTOWN DENTAL PROFESSIONALS, PC
INSURANCE VERIFICATION FORM

Date: _____
Patient Name: _____
Patient SS#: _____
Patient DOB: _____
Student Status: _____

Insured Name: _____
Relationship to Patient: _____
Insured SS#: _____
Insured ID# (if different than SS#): _____
Insured DOB: _____
Employer: _____
Group# _____

Insurance Company Name: _____
Phone Number: _____
Claims Address: _____
_____
_____

For Office Use:

Effective Date: ____-_____-_____

Maximum: $ _____
Deductible: $ _____
Preventative: _____%
Basic: _____%
Major: _____%
Implants: _____%

Calendar year: ☐ Yes ☐ No _____
Amount met: $ _____
Perio: _____%
Endo: _____%
Oral Surgery: _____%
Ortho: _____%

Frequency Limits:
FMX: _____
Sealants: _____
Night Guard: _____
Fixed Prosthodontics: _____
Removable Prosthodontics: _____

Missing tooth clause: ☐ Yes ☐ No
5 year clause: ☐ Yes ☐ No
Any waiting periods: ☐ Yes ☐ No

Other notes:
_____
_____
_____