VIPS INSURANCE FORM

DATE: _____ INITIALS: _____ **PATIENT NAME**: _____

SSN: _____D.O.B.: _____SPOUSE: _____

IF CHILD- PARENT'S NAME: _____ APPT. TIME & DATE:_____ @ _____

Surgery Type: **4/3's / EXT / Dental Implant / Bone Graft / IV sedation / Nitrous Oxide / Local**

INS. CARRIER NAME: _____ EMPLOYER: _____

INS. PHONE: _____ GROUP# _____

SUBSCRIBER: _____ DOB: _____ RELATION TO PT: _____

SSN #: _____ ID# _____

INSURANCE VERIFICATION

WE ARE AN OUT OF NETWORK PROVIDER:

Date: _____Rep Name: _____ Effective Date: _____

Ded:_____ / Met: _____ **Family Ded**: _____ / Met:_____ **Max:** _____ Used: _____

Preventative: _____ - **Ded applies**? Y / N **Basic**: _____% **Ded. applies**? Y / N **Major:** _____ Ded? Y / N

Plan or Cal Year / If plan year, month it begins:_____/ **Oral Surgery** covered under? Basic or Major @ _____%

Dental Implants covered?(D6010) **Y / N / OR subject to review?** If covered @ _____**%. Is there a m**issing tooth clause? Y / N

Bone graft D7953 covered? Y / N @ _____%. Is IV Sedation covered? (D9241 and D9242) Y / N @ _____ %.

Wisdom Teeth Extractions (D7210 / D7220 / D7230 / D7240 / D7241) Y / N covered at _____ %. Subject to Medical Denial 1st? YES /NO

Frequencies

Pano:D0330: _____ per _____ Eligible? **Y / N** History: _____ / D0150: ____ per _____ Eligible? **Y / N** History: _____

Exams:D0140: ____ per _____ Eligible? **Y / N** History: _____ / D0180: _____ per _____ History: _____

Claims Mailing Address:

_____

_____

_____

Payor ID: _____

Pre-Determination Address:

_____

_____

_____

Claims Fax: _____