Clear Dental Billing

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Orthodontic Insurance Verification

Exported by Clear Dental Billing · Sample form

Verification as of —

PATIENT & COVERAGE

Patient:	DOB:
Subscriber:	Sub DOB:
Member ID:	Group #:
Group:	Carrier:
Coverage:	Network:
Provider:	Provider NPI:

BENEFIT BREAKDOWN

PLAN

Payer	
Plan Name	
Group Name	
Group Number	
Coverage status	
Network Status	
Payer ID	
Reference #	
Representative	
Effective date	
Insurance phone #	
Claim address	

ORTHO

Orthodontic coverage?	
Lifetime coverage	
Lifetime remaining	
Pays at	
Benefits used?	
Orthodontic deductible	
Per year or lifetime?	
Waiting period	
Treatment in progress coverage?	
Space maintainer coverage	
Space maintainer limitations	

HMO COPAYS

HMO / copay plan?	

PAYOUT

How are benefits paid out?	
Payout frequency	
Down payment / banding (% or $)	
If %, pays from tx fee or lifetime max?	

LIMITS

Dependent age limit	
When does it term for dependent?	
Subscriber / spouse age limit	
Coordination of benefits (COB)	