PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

DENTAL INSURANCE VERIFICATION FORM

Use this form as a template for documenting dental benefits when calling Customer Service for a dental benefit quote.

Date: ________________

PATIENT/SUBSCRIBER INFORMATION

Patient Information

Patient Name: ___________________________________

Date of Birth: ____/____/________ Age: _______

SSN#: ______________________

Subscriber Information

Subscriber Name: ________________________________

Date of Birth: ____/____/________

Subscriber ID#: __________________________________

Plan/Group#: _________________

Employer Name: _________________________________

Insurance Information

Insurance Name: _________________________________

Insurance Address: _______________________________

Insurance Phone: _______________ Payor ID: _________

Insurance Effective Date: ____/____/________

Standard COB: Y / N

Waiting Period: Y / N

Year Type: Calendar / Plan

Individual Deductible: $________ Met to date: $_________

Family Deductible: $_________ Met to date $_________

Deductible applies to: Preventive / Basic / Major

Dental Maximum: $_______________

DENTAL BENEFITS

Class I: Preventive_____%

Routine oral exam - Frequency: ______________________

Routine prophylaxis - Frequency: ____________________

Bitewings - Frequency: _____________________________

Panoramic/FMX - Frequency: ________________________

Fluoride - Frequency: ______________ Age Limit: ______

Sealant - Frequency: ______________ Age Limit: ______

(Sealants limited to Permanent Teeth Only)

Class II: Basic_____%

Fillings - Frequency: ______________________________

Posterior composites reduced on 2nd or 3rd molars: Y / N

Simple extractions

Periodontal maintenance - Frequency: ________________

Class III: Major_____%

Crowns, inlays, onlays, labial veneers, bridge, dentures

Prosthetic Replacement Limitation: ___________________

Missing Tooth Clause: ___________________

Implants Benefits: Y / N

Allowable under Basic or Major:

Endodontic: Basic / Major

Perio Scaling: Basic / Major - Frequency: ______________

Osseous Surgery: Basic / Major - Frequency: ___________

Surgical Extractions: Basic / Major

Oral Surgery: Basic / Major

Nightguards (Bruxism): Basic / Major - Frequency:_______

Orthodontia: _____%

Orthodontia Lifetime Deductible: $__________ Orthodontia Lifetime Deductible Met to date: $___________

Diagnostic & Banding Maximum (applies to Orthodontia Lifetime Max): $___________

Lifetime Orthodontia Maximum: $_______________ Age Limit: _______

Disclaimer: This is a summary of plan benefits and is not intended to be a contract. Actual coverage will be determined when the claim is processed subject to all contract terms, including, but not limited to, member benefits, benefit maximums and subscription charge payment covering the actual dates of service. This is not a dental pre-determination of benefits or a guarantee of payment.

All services are subject to review of Premera processing policies, medical vs. dental benefit application, dental necessity, cosmetic, and/or alternative benefit.