DENTAL Insurance Verification of Coverage

Dr. Alex J. Johnson, D.M.D., M.S.

OFFICE USE ONLY

DATE

Patient Name _____D.O.B. _____

Insured Name _____D.O.B. _____

Insured Address _____SS# _____
_____

Insured Employer_____

Insured's Group# _____ID# _____

Insurance Company Name _____

Insurance Company Address_____
_____

Insurance Company Phone# _____

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Ins Effective Date_____ Adults *Y / N* Age Limit _____

Max Amt. (O) $_____ *LT / YC* Percent_____ Deductible _____

Max Remaining $_____ Portion Used $_____ % Initial Pmt _____

Phase 1 Tx. (8060) ***Y / N***
TMD Splint (7880) ***Y / N*** _____%
Brux Splint (9940) ***Y / N*** _____% Work in progress ***Y / N***

Payments – ***To Member*** / *Monthly / Quarterly / Bi-annual / In Full*

Auto to provider ***Y / N*** & **BILL** *Mo / Quar* Wait period ***Y / N***
Payor ID # _____ Until _____