INSURANCE INFORMATION FORM

Employer Name_____ **Phone**_____
Address_____

_____
Contact_____

Insurance Co_____ **Group #**_____
Address_____ **Phone**_____

_____
Contact_____
Date of Inquiry_____ **Updated**_____

BENEFITS INFORMATION:

Traditional Dental_____ **Self Insured**_____ **Managed Care**_____
Yearly Maximum_____ **Lifetime Maximum**_____
Deductible amount_____ **Family?**_____ **Dental Only?**_____**Applied to**_____
Benefit Year_____
Do you use fee schedule?_____ **(request booklet)**
Is pre-authorization mandatory?_____
If we do not pre-authorize, will benefits be paid differently?_____
Do you coordinate benefits with secondary carrier?_____
Are there any restrictions or limitations on payment?_____
Waiting period for major dental_____
Do you accept electronic claims?_____
What is the "Payer ID#" that is required to process electronic claims?_____
Do you pay for replacement of missing teeth?_____

_____**%**_____
_____

_____**%**_____
_____

_____**%**_____
_____

Additional information and limitations:_____
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