# INSURANCE VERIFICATION FORM

ORTHO_____ TMJ_____

DATE:_____

INSURED'S NAME:_____DOB_____
INSURED'S SS#_____EMP_____
MEMBER # IF DIFFERENT THAN SS#_____

INSURANCE CO. NAME_____GROUP/PLAN_____
INSURANCE CO PHONE#_____

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EFFECTIVE DATE:_____PRE-ESTIMATE REQUIRED_____
DENTAL____MEDICAL_____FILE MTHLY____QUARTERLY____AUTO_____
VERIFICATION OF CO'T TX NEEDED: YES____NO____

DED AMT_____DED AMT MET_____% INS PAYS_____AGE LIMIT_____
DOLLAR LIMIT_____LIFETIME_____YEARLY_____ADULT COV_____
IS LIMITED/INTERCEPTIVE TX A COVERED EXPENSE? YES____ NO____

CLAIMS MAILED TO:_____
_____
_____
PAYOR #_____ OMS COMPUTER #_____

INSURANCE CO REP THAT VERIFIED INFO:_____
CHASTANT STAFF CONFIRMING INFO:_____