INSURANCE BREAKDOWN FORM

Excel Dental Solutions

DATE _____

PATIENT/SUBSCRIBER INFORMATION

PATIENT INFORMATION

PATIENT NAME_____

DATE OF BIRTH_____

SSN# _____

ALT ID# _____

EMPLOYER _____

IS PATIENT THE POLICY HOLDER? ☐ YES ☐ NO

(IF NO PLEASE FILL OUT SUBSCRIBER INFORMATION)

SUBSCRIBER INFORMATION

SUBSCRIBER NAME _____

DATE OF BIRTH _____

SSN# _____

ALT ID# _____

EMPLOYER _____

RELATIONSHIP TO PATIENT (select)

INSURANCE INFORMATION

INSURANCE NAME _____

CLAIM MAILING ADDRESS _____

_____

INSURANCE PHONE _____COVERAGE EFFECTIVE ON _____

COORDINATION OF BENEFITS _____

CALENDAR YEAR JAN

INDIVIDUAL DED _____ MET TO DATE _____

FAMILY DED _____ MET TO DATE _____

ANNUAL MAX _____ BENEFITS REMAINING _____

DENTAL BENEFITS INFORMATION

DIAGNOSTIC _____% DED APPLIES ☐

PREVENTATIVE _____% DED APPLIES ☐

ENDODONTICS _____ % DED APPLIES ☐

ORAL SURGERY _____% DED APPLIES ☐

SIMPLE _____% *SURGICAL* _____%

RESTORATIVE BASIC _____% DED APPLIES ☐

PERIODONTICS _____ % DED APPLIES ☐

RESTORATIVE MAJOR _____% DED APPLIES ☐

PROSTHODONTICS, FIXED _____% DED APPLIES ☐

PROSTHODONTICS, REMOVABLE _____% DED APPLIES ☐

IMPLANT SERVICES _____% DED APPLIES ☐

ORTHODONTICS _____% DED APPLIES ☐

ADJUNCTIVE GENERAL SERVICES _____% DED APPLIES ☐

EXAMS: 0 IN (select) LAST DOS _____

PROPHY: 0 IN (select) LAST DOS _____

FMX: 0 IN (select) LAST DOS _____

PANO: 0 IN (select) LAST DOS _____

AGE LIMITATION FOR FLOURIDE _____ COVERED? (select)

AGE LIMITATION FOR SEALANTS _____ COVERED? (select)

ARE POSTERIOR COMPOSITES COVERED? (select)

IMPACTED EXTRACTION COVERED UNDER ☐ DENTAL ☐ MEDICAL

WAITING PERIOD*(IF APPLICABLE):* BASIC SATISFIED ON _____

MAJOR SATISFIED ON _____

MISSING TOOTH CLAUSE (select)

REPLACEMENT: CROWNS & BRIDGES (select) YRS,

DENTURES (select) YRS.

ASSIGNMENT OF BENEFITS ☐ PROVIDER ☐ PATIENT

SPOKE WITH _____ CALL REF _____

ADDITIONAL NOTES _____

_____

CALLED BY (PRINT NAME)_____

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PRINT

CLEAR FORM