

INSURANCE VERIFICATION FORM

As a service to our patients, we accept and file dental insurance. However, **YOU are responsible for ALL communication with your insurance company** except for additional information required of this office pertaining to specific procedures. We are providing you with this form which has the necessary questions for you to ask regarding your coverage when you call your ins. co. Based on this information, we can estimate what your payment should be at the time of service. Ultimately, you are responsible for all charges/balances/unpaid claims. Please complete this form and return it with a copy of your insurance card. Please understand that dental insurance is intended to cover some, but not all, of the cost of your dental care. Most plans include a deductible and certain other expenses, which must be paid by the patient at the time of service. **We cannot stress enough that insurance payment is not, and has never been, a guideline for quality care.** If you have any questions, please contact Becky at ext. 302 or email her at finance@ashevillefamilydentistry.com. Thank you!

Patient Name _____ Policy Owner's Name _____

Policy Holder's DOB _____ SSN _____ Relationship to Patient _____

Insured's Employer _____ Ins. Co. Name/Address _____

_____ Phone No. _____ Group # _____

CALL THE 1-800 # ON YOUR INS. CARD TO COMPLETE SECTION BELOW:

Is it a calendar or fiscal year? _____ Policy effective date: _____

YEARLY MAXIMUM \$ _____ Deductible \$ _____ Does it apply to preventative? _____

X-RAY HISTORY _____

COVERAGE: Preventative _____% Basic _____% Major _____%

Perio _____% Endo _____% Oral Surgery _____% Implant crowns covered? _____

Waiting Periods? _____ Missing Tooth Clause? _____ Replacement time for partials,
dentures, crowns, bridges _____ yrs Downgrade for posterior composite fillings? _____

FREQUENCY: Cleanings _____ Bitewings _____ FMX/Panoramic _____

At what % is **Nitrous Oxide** (code # 9230) / **Sedation** (code #9248) covered? _____

Is payment based on **Usual & Customary Rates** (UCR) or **Fixed Rates**? _____

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. Abernathy all insurance benefits otherwise payable to me. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

***I realize if this information is not completed prior to my first appointment, I will be responsible for payment in full that day.**

Signature

Date