Dentovio

Dental insurance verification form

Blank worksheet for eligibility, benefits remaining, procedure limits, payer evidence, and estimate caveats.

Last verified 2026-08-30. Educational operations template only -- not a guarantee of payment.

Patient + plan

- Patient name
- Patient date of birth
- Subscriber name
- Subscriber relationship
- Carrier and plan name
- Member ID / group number
- Employer or plan sponsor
- Payer ID

Eligibility evidence

- Date of service verified
- Active status
- Effective date
- Termination date
- Verification method
- Representative or portal source
- Call reference number
- Screenshot or note location

Money fields

- Plan year
- Annual maximum
- Amount used
- Maximum remaining
- Deductible total
- Deductible remaining
- Preventive / basic / major coverage
- Ortho or implant maximum

Treatment estimate

- Procedure category
- Planned codes or code family
- Tooth / surface / quadrant
- Waiting period
- Frequency or replacement limit
- Prior authorization needed
- Attachments requested
- Patient estimate caveat

Confirm plan-specific rules with the payer and the patient’s plan documents before quoting a patient portion.

Payer call script

Work the script top to bottom during the call, then file the reference number and caveats with the estimate.

Open the call

I am calling from the dental office to verify eligibility and procedure-level benefits for an upcoming date of service. I need active status, remaining benefits, limitations, and a reference number for our records.

Anchor the date

Please verify coverage for this specific date of service: __/__/____. Is the patient active on that date, and are there any pending termination, COBRA, leave-of-absence, or employer-status issues showing?

Get the money fields

What is the plan year, annual maximum, amount used, annual maximum remaining, deductible total, deductible remaining, and category coinsurance for preventive, basic, major, perio, oral surgery, prosthodontics, implants, and orthodontics?

Drill into the procedure

For the planned procedure category, are there waiting periods, frequency limits, age limits, tooth or quadrant restrictions, replacement intervals, missing-tooth clauses, alternate benefits, downgrades, documentation requirements, or predetermination requirements?

Close with evidence

Can you give me your name or operator ID, the call reference number, and any exact caveat you want us to include when presenting this as an estimate rather than a guarantee of payment?

Estimate handoff language

Clean patient estimate

Based on the benefits verified today, your estimated portion is $____. Insurance payment is not guaranteed until the claim is processed, and the final balance can change if eligibility, plan maximum, deductible, frequency limits, or payer processing changes.

Dual coverage handoff

The patient has two plans. Identify the primary plan, the reason it is primary, and the secondary plan’s coordination method before quoting a patient portion.

Predetermination caveat

A predetermination can help estimate benefits before treatment, but it is not a guarantee of payment: the patient must remain eligible, and the plan maximum cannot be exhausted before the date of service.

What the verification form captures

Why each category belongs in a benefits breakdown -- useful when training front-office staff on the worksheet.

Patient and subscriber

Fields: Patient and subscriber names, dates of birth, relationship, employer or plan sponsor, carrier, plan name, member ID, group number, and payer ID.
Why it matters: Ties the eligibility check to the correct subscriber, group, and payer record before a treatment estimate is created.

Eligibility evidence

Fields: Date of service, active status, effective date, termination date if shown, verification method, representative or portal source, call reference, and saved screenshot location.
Why it matters: Creates a dated evidence trail for the eligibility answer instead of relying on an undocumented portal glance.

Benefits money

Fields: Plan year, annual maximum, amount used, maximum remaining, deductible total, deductible remaining, and category coinsurance.
Why it matters: Separates active coverage from the money that can still change the patient’s estimated portion.

Procedure-level rules

Fields: Planned code family, waiting periods, frequency limits, age limits, tooth/surface/quadrant restrictions, replacement intervals, missing-tooth clauses, and alternate-benefit language.
Why it matters: Captures the plan restrictions the payer states for the planned procedure, in the payer’s own terms.

Submission requirements

Fields: Predetermination or prior authorization, radiographs, intraoral photos, periodontal charting, narratives, clinical notes, portal attachments, and timely filing notes.
Why it matters: Shows what the office must gather before claim submission or before presenting a higher-cost estimate.

COB and estimate handoff

Fields: Other coverage, primary plan, primary-order reason, secondary method, estimated patient portion, estimate caveat, team initials, and recheck date.
Why it matters: Turns verification into a handoff the treatment coordinator can use without implying a payment guarantee.

Procedure-specific payer prompts

Questions to put to the payer for the planned procedure category. Whether a limit exists -- and what it is -- comes from the payer.

Diagnostic / preventive

Verify: Coverage %, deductible applies, frequency, age limits, last service date
Ask how many exams, cleanings, fluoride applications, sealants, and radiographs are allowed in the plan period and whether the deductible applies.

Restorative

Verify: Coverage %, deductible, alternate benefit, downgrade, tooth/surface limits
Ask whether the planned restoration is subject to alternate-benefit, downgrade, tooth, surface, or frequency language.

Endodontic

Verify: Coverage %, waiting period, tooth limits, radiograph requirements
Ask whether the tooth and procedure category have waiting periods, radiograph requirements, or prior-review language.

Periodontal

Verify: Coverage %, frequency, treatment history, perio charting, radiographs, narrative
Ask about scaling and root planing history, maintenance frequency, charting, radiographs, and narrative requirements.

Oral surgery

Verify: Coverage %, dental vs. medical coordination, radiographs, surgical notes
Ask whether dental or medical coverage is primary for the planned surgery and what radiographs or notes are requested.

Crowns / prosthodontics

Verify: Coverage %, replacement interval, missing-tooth clause, prep-date rule, downgrade language
Ask about the replacement interval, missing-tooth clause, buildup or core language, prep-date rules, downgrade language, and predetermination needs.

Implants

Verify: Covered or excluded, alternate benefit, medical coordination, authorization
Ask whether implants are covered, excluded, downgraded to another benefit, coordinated with medical, or subject to authorization.

Orthodontics

Verify: Lifetime max, age limit, waiting period, work-in-progress rules, payment schedule
Ask about the orthodontic lifetime maximum, age limit, waiting period, work-in-progress rules, payment schedule, and remaining benefit.

Fictional completed verification note

This example shows how the worksheet becomes a concise internal handoff. The names, dates, amounts, and reference number are fictional and should not be copied into a real patient record.

Patient / subscriber

Jordan Lee / Morgan Lee, spouse

Date of service checked

09/14/2026

Verification source

Payer portal screenshot saved to the patient estimate packet

Eligibility status

Active for the checked date of service; no employer change reported

Plan identifiers

Carrier: Example Dental PPO; group: 12345; member ID ending 7890

Benefits money

Annual maximum $1,500; amount used $350; maximum remaining $1,150; deductible remaining $0

Procedure-level rule

Major services 50% after deductible; the payer stated a 5-year crown replacement interval

Submission requirement

Predetermination recommended for the crown estimate; radiograph and narrative requested

Evidence trail

Portal checked 2026-08-12 at 10:15 AM; internal reference EX-271-4482

Patient-facing caveat

Estimate is based on benefits verified today and is not a guarantee of payment; the final balance can change after claim processing.

Handoff guardrail

The treatment coordinator quotes from the worksheet only after confirming the planned procedure, remaining maximum, deductible, replacement interval, and predetermination requirement match the treatment plan.