Dentovio

Dental insurance verification form

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

Last verified 2026-07-09. Educational operations template only.

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

Payer call script and estimate handoff

Use these notes after the blank form is filled. Keep payer screenshots, call references, and caveats with the estimate.

Payer call script

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. Verify which plan is primary, identify the secondary COB method, then run the Dentovio COB calculator before quoting the patient portion.

Predetermination caveat

A predetermination can help estimate benefits before treatment, but the patient must remain eligible and cannot exhaust the plan maximum before the date of service.

What the verification form captures

Use this page to explain why each category belongs in a dental benefits breakdown.

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: Catches the restrictions that can make a covered category pay differently for the planned procedure.

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.

Sample completed verification note

Use this example to see how the worksheet can become 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

08/14/2026

Verification source

Payer portal screenshot saved to patient estimate packet

Eligibility status

Active for the checked date of service; employer change denied by patient

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; crown replacement interval noted as 5 years

Submission requirement

Predetermination recommended for crown estimate; radiograph and narrative requested

Evidence trail

Portal checked 2026-07-09 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; final balance can change after claim processing.

Handoff guardrail

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

Start here and procedure-specific prompts

Use this page before discussing the patient estimate or calling the payer.

Start here

If the visit is today

Verify active eligibility for today's date of service, then save the portal evidence or call reference before quoting benefits. Why: Eligibility can change between scheduling and treatment, so the estimate needs a dated source.

If treatment is expensive or delayed

Recheck benefits close to the appointment and confirm maximum remaining, deductible remaining, frequency limits, replacement intervals, and documentation needs. Why: High-cost estimates are more exposed to maximum use, plan changes, and procedure-level restrictions.

If the patient has two plans

Identify the primary plan, secondary plan, primary-order reason, and secondary COB method before calculating patient portion. Why: Dual coverage math depends on primary order and the secondary coordination method, not only on each plan's coinsurance.

If the estimate will be discussed with the patient

Use a non-guarantee estimate caveat and save the verification evidence with the treatment estimate. Why: A clear handoff reduces overpromising and gives the team a source trail if the final EOB differs.

Procedure-specific prompts

Diagnostic / preventive

Fields: Coverage %, deductible applies, frequency, age limits, last service date Ask payer: Ask how many exams, cleanings, fluoride applications, sealants, and radiographs are allowed in the plan period and whether deductible applies. Estimate risk: Frequency, age, and last-service limits can change a routine estimate even

Restorative

Fields: Coverage %, deductible, alternate benefit, downgrade, tooth/surface limits Ask payer: Ask whether the planned restoration is subject to alternate benefit, downgrade, tooth, surface, or frequency language. Estimate risk: A category percentage can overstate payment when the payer applies an alternate benefit or surface limit.

Endodontic

Fields: Coverage %, waiting period, tooth limits, pre-op radiograph requirements Ask payer: Ask whether the tooth and procedure category have waiting periods, radiograph requirements, or prior review language. Estimate risk: Endodontic estimates can move when the payer requires documentation or treats the tooth as ineligible

Periodontal

Fields: Coverage %, frequency, SRP history, perio charting, radiographs, narrative Ask payer: Ask about scaling and root planing history, maintenance frequency, charting, radiographs, and narrative requirements. Estimate risk: Periodontal benefits often depend on history, frequency, and documentation rather than category coverage

Oral surgery

Fields: Coverage %, medical-primary possibility, radiographs, surgical notes Ask payer: Ask whether dental or medical coverage is primary for the planned surgery and what radiographs or notes are requested. Estimate risk: Medical-primary or documentation rules can change the handoff before the patient hears an out-of-pocket

Crowns / prosthodontics

Fields: Coverage %, replacement interval, missing-tooth clause, prep date rule, downgrade language Ask payer: Ask about crown replacement interval, missing-tooth clause, build-up or core language, prep-date rules, downgrade language, and predetermination needs. Estimate risk: Major-service percentages can be misleading when

Implants

Fields: Covered or excluded, alternate benefit, medical coordination, authorization requirements Ask payer: Ask whether implants are covered, excluded, downgraded to another benefit, coordinated with medical, or subject to authorization. Estimate risk: Implant estimates need explicit exclusion, downgrade, and authorization language

Orthodontics

Fields: Lifetime max, age limit, waiting period, work-in-progress rules, payment schedule Ask payer: Ask about orthodontic lifetime maximum, age limit, waiting period, work-in-progress rules, payment schedule, and remaining benefit. Estimate risk: Orthodontic payment timing and lifetime maximums can matter more than a single coverage