INSURANCE VERIFICATION CHECKLIST

Practice: _____ Date: _____

Prepared by: _____

SECTION A: PATIENT INFORMATION

- ☐ Patient Name
- ☐ DOB
- ☐ Employer
- ☐ Group #
- ☐ Subscriber ID

SECTION B: COVERAGE DETAILS

- ☐ Frequency Limits (Exam / X-ray / Prophy)
- ☐ Annual Maximum
- ☐ Deductible
- ☐ Waiting Periods
- ☐ Downgrades / Alternate Benefits

SECTION C: VERIFICATION CONFIRMATION

Date of Call: _____

Rep Name: _____

Reference #: _____

Notes: _____

continued...

SECTION D: ACCOUNTABILITY

Verified by: _____

Reviewed by: _____

Date: _____

SIGN-OFF

Manager: _____ Doctor: _____ Date: _____

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