ORTHODONTIC BENEFIT WORKSHEET

PRIMARY / SECONDARY

DATE _____ **REP** _____

PATIENT NAME _____ **DOB** _____

SUBSCRIBER _____ **SSN# OR ID#:** _____ **SUB. DOB** _____

INSURANCE CARRIER _____ **PHONE# ( )** _____

CLAIMS ADDRESS _____ ☐ PRE-AUTH ONLINE!!

EMPLOYER _____ **GROUP#** _____ **FEE SCH** _____

PLAN TYPE: PPO / DHMO / PREMIER / INDEMNITY EFF. DATE _____

DEP COVERED TO AGE _____ **STUDENTS TO AGE** _____ **PATIENT AGE** _____

ORTHO COVERED YES / NO LIFETIME MAX $ _____ **REMAINING $** _____ **ORTHO DED $** _____

COVERAGE _____ **% AGE LIMIT: ADULTS** _____ **CHILDREN** _____ **WAITING PERIOD** _____

D8070 TRANSITIONAL _____ **% D8080 ADOLESCENT** _____ **% D8090 ADULT** _____ **%**

D8670 PERIODIC VISIT _____ **% D8680 RETENTION** _____ **% RETAINER REPLACEMENT COVERED / NC**

BANDING DATE REQUIRED YES / NO BANDING DATE _____ **EST. MONTHS OF TX** _____

WORK IN PROGRESS COVERED YES / NO PRIOR ORTHO PAID BY OTHER PLAN $ _____

INS WILL PAY: AUTO / MONTHLY / QUARTERLY / LUMP SUM INITIAL PAYMENT _____ **%**

PAYS TO: OFFICE / PATIENT ASSIGNMENT OF BENEFITS ACCEPTED YES / NO

PRE-AUTH / PRE-D REQUIRED YES / NO TIMELY FILING _____ **CLAIM FORM ADA / PAYER**

DIAG/PREV _____ **% EXAM FREQ** _____ **PANO D0330 FREQ** _____ **CEPH D0340 COVERED / NC**

SECONDARY PLAN? YES / NO COB METHOD _____ **CARRIER** _____

PRIOR ORTHO HISTORY (TX, DATES, PROVIDER) _____

PENDING CLAIMS: _____

NOTES: _____

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