PEDIATRIC BREAKDOWN OF BENEFITS

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 _____

MAXIMUM $ _____ **CAL / CONT DED $** _____ **MET: YES / NO WAIVED YES / NO**

REM MAX $ _____ **DIAG/PREV COME OUT OF MAX: YES / NO WAITING PERIOD** _____

PATIENT AGE _____ **DEP COVERED TO AGE** _____ **STUDENTS TO AGE** _____ **MISSING TOOTH CLAUSE YES / NO**

EXAM D0120 / D0145 _____ **% FREQ** _____ **PROPHY D1120** _____ **% FREQ** _____

BWX D0272 / D0274 _____ **% FREQ** _____ **PANO D0330** _____ **% FREQ** _____ **SHARED / SEP.**

FLUORIDE D1206 / D1208 _____ **% FREQ** _____ **AGE LIMIT** _____

SEALANTS D1351 _____ **% FREQ** _____ **PER TOOTH TEETH COVERED** _____ **AGE LIMIT** _____

SPACE MAINT D1510 / D1516 / D1517 _____ **% PRE-AUTH YES / NO FREQ** _____

SDF D1354 _____ **% FREQ** _____ **AGE LIMIT** _____ **PER TOOTH YES / NO**

BASIC _____ **% | AMALGAM D2140** _____ **% COMPOSITE D2391** _____ **% POST COMP COVERED or REDUCED**

SS CROWN D2930 _____ **% FREQ** _____ **PULPOTOMY D3220** _____ **%**

EXTRACTION D7140 _____ **% OS % (SURGICAL)** _____ **ENDO %** _____

NITROUS D9230 COVERED / NC BEHAVIOR MGMT D9920 COVERED / NC SEDATION D9248 COVERED / NC PRE-AUTH YES / NO

ORTHO COVERED YES / NO LIFETIME MAX $ _____ **COVERAGE** _____ **% AGE LIMIT** _____ **WAITING PERIOD** _____

HISTORY: EXAM _____ **PROPHY** _____ **FLUORIDE** _____ **BWX** _____ **PANO** _____

SEALANTS PLACED (TEETH, DATES) _____

PENDING CLAIMS: _____

NOTES: _____