Insurance Questions

Name of policy holder/subscriber: ________________________________

Birthday of policy holder/subscriber_________________________

Member/subscriber ID: _____________________________

Group Number: _________________________________

Do I have out of network benefits? ____________

Fee schedule used for out of network dentist. UCR (usual, customary, reasonable _____ or Other _____

Where will insurance payments go if out of network? Patient _____ dental office _____

Benefit year? Calendar year ______ Other ______

My maximum amount $____________

Benefit maximum per individual or shared with family? ________________

Remaining maximum as of today? ____________

Does the benefit maximum & deductible apply to my exams, x-rays and cleanings? _____

What is my individual deductible? ______________

What is my family deductible? ______________

How much of my deductible is remaining as of today? __________