MALVERN TOWN CENTRE DENTAL

(Please circle)
Ins Info Already on File OR needed A.S.A.P.
Spoke to _____

Insurance Breakdown

Date:_____ Name of Insurance Company:_____

Name of Insured Member:_____

Group Number: _____ I.D.# _____

1. What Fee Guide: Current or Other _____
2. Assignment allowed? Yes or No
3. Is your plan on a Calendar Year: Yes or No
   Other: _____to_____
4. Is there a deductible. If Yes, Single:_____ or Family:_____
5. Basic treatment is covered at: _____% with a maximum of $_____
6. Does it include endo and perio? Yes or No
7. Major treatment is covered at _____% with a maximum of $_____
8. Are the basic and major maximum: Combined or Separate
9. Is there any coverage for Orthodontics: Yes or No

   If yes, covered at _____% with a maximum of $_____

   With an Age limit of: _____yrs
10. Please indicate 6, 9, 12, 24 or 36 month interval for each of the following:

Recall Exam:	_____months	Complete Exam:	_____months
Full Set of X-rays:	_____months	Panoramic X-ray:	_____months
Bitewings X-rays:	_____months	Polishing:	_____months
Fluoride:	_____months *and* Age limit?		_____yrs

   Oral Hygiene Instruction: Yes or No Any limitations? _____
11. Number of scaling units allowed each benefit year _____units Calendar Year or Rolling Months
12. Are Composite (white) Fillings allowed on molars? (23321) Yes or No
13. Are Pit and Fissure Sealants covered? (13401) Yes or No
14. Is there any coverage for Implants? (79931) Yes or No
15. Mailing address for all claims _____