Medical Phone Pre-Determination/Authorization Intake

Date______________ Time_________AM/PM Call Reference# ____________________________

Name of Rep___________________________ Direct Phone/Ext_____________________________

Subscriber Name_______________________ Subscriber ID________________________________

Patient Name____________________________ Relationship to Subscriber___________________

Dependent Coverage Y/N If *Yes*, Who ____

Member/Group # ____________________ Policy Renewal Date_____________________________

Insurance Carrier_______________________________ Mailing Address__________________________

Pre-D Necessary? Y/N If Yes, How to Handle____________________Pre-D Phone #______________

Treatment Plan/Letter of Medical Necessity ____

Fax Info for LMN_______________ Name_________________ Direct Fax # ____________________

Doctor____________________________Place of Service__________________Preferred Provider? Y/N

Gap Exclusion? Y/N , If *Yes*, Reference # ________________________Do they accept CDT Codes? Y/N

Plan Benefits: Basic_______________ Major_______________ Comprehensive______________

Annual Maximum_________ Deductible___________ In/Out of Network____________________

Deductible Met____________ Deductible Left__________ Replacement Time Period_________

Do you categorize appliances as DME (Durable Medical Equipment) Y/N

What is the co-insurance for appliances?____

Appliances? ___________ Is there a Global Period?________How Long is Global Period?______________

Allowable Benefit Fee Range____

Are our fees within Benefit Range? Y/N Special Qualifications?________________________________

Procedure Limitations____

Percentage of Coverage____

Dental Administrator's Name____