

Dentistry on Wilson Benefit Information

Primary

Subscriber: _____

D.O.B. _____

Employer: _____

Benefit Company: _____

Policy #: _____

Certificate #: _____

Assignment plan : Y / N

Deductible: \$ _____

Fee Guide Year: _____

Basic maximum \$ _____

Major Maximum\$ _____

Ortho Max\$ _____ per _____

Is it a calendar or contract year?

Basic Dental _____%, Endo _____%,

Perio _____%? Emergency _____%

Major _____%? Ortho _____%

Ortho age limit? _____

Complete Oral Exam frequency: _____

Full Mouth Series of X-Rays? _____ freq

Scaling/root planning units: _____

Recall exam? _____

Polish? _____

Fluoride? Y / N Adult Fluoride? _____

Does your insurance cover white fillings on molars? _____

PAN freq: _____ B.W.'s freq: _____

Specific Exams: _____

Implant coverage: _____

Secondary

Subscriber: _____

D.O.B. _____

Employer: _____

Benefit Company: _____

Policy #: _____

Certificate #: _____

Assignment plan : Y / N

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Fee Guide Year: _____

Basic maximum \$ _____

Major Maximum\$ _____

Ortho Max\$ _____ per _____

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Specific Exams: _____

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