Dental Insurance Information

Following is a list of information regarding your benefits. This is information you should be aware of. It is your responsibility to be in contact with your insurance provider to check on various exceptions. Please keep in mind; they are not only limited to the following procedures:

Pre-existing condition: insurance companies **will not pay** on any existing crowns if they have been placed within the last 5 or 8 years. You need to contact your insurance carrier and find out when your crowns were last placed.

Composite (white fillings) vs. Amalgam (silver fillings): Many insurance companies will not pay for composites or will pay less for composite filings in any of the posterior (back) teeth.

Implant crowns vs. regular crowns: The code for porcelain over metal crown is 2750. The code for a crown over an implant is 6059. Most insurance companies will not pay for an implant crown. Please be aware that the code for an implant crown must be filed as 6059 and not 2750. When you call your insurance carrier please be sure to ask about code 6059 for implant crown coverage.

Secondary Insurance: We will submit claims to the primary insurance carrier, however: the patient is responsible for sending claims to any secondary insurance. We will be happy to print out a super bill with all of the necessary information needed to send to your insurance.

Usual and Customary: Many insurance policies will quote a percentage of coverage for the various procedures followed by "U & C". "Usual and Customary" is a dollar amount that the insurance company deems as the amount that will be covered. A $1500 crown covered at 50% does not always (almost never) equal $750. If the UC on your policy is $700 for a crown, then 50% of your $1500 crown is now $350. The remaining balance of $1150 would then be the patient's responsibility.

Waiting Periods: Some new policies have "waiting periods". This means that some or all procedures may not be covered for X amount of time (refer to **your** insurance policy manual).

Annual Maximums: Many people are under the impression that if they have an annual maximum of $2000.00, then they will automatically be entitled to the whole amount by the end of the year. This is not always true. Payment on each claim is determined by many variables. Some determining factors are frequency, UC, waiting periods, covered procedures, age limitations, or necessity (refer to **your** policy manual).

We will gladly submit dental claims to your primary insurance company as a courtesy to you. If payment is not received from the insurance company within 30 days, the patient is responsible for their account balance at that time. A credit will be issued to the patient should the insurance payment be received after the balance was paid in full.

Your policy is a contract between you & your employer. It is your responsibility to know your contract and benefits. Although we will assist you by filing your insurance, we will not be responsible for any procedures not covered due to contract stipulations. Insurance companies typically respond better to inquiries made by the patient rather than the provider's office. Remembers, estimates given are purely estimates and any difference will be owed by the patient.

I have read and understand the above insurance benefit information. I realize every insurance contract is different and that I am responsible to know my own policy benefits and limitations.

Patient signature_____ **Date**_____