



Insurance Breakdown Form

Welcome to Westmount Dental.

Due to the current Privacy Legislation, insurance companies are no longer allowed to release your private information if we contact them on your behalf. Please spend a few minutes on the phone with your insurance provider and complete this form so that we may help you understand your dental benefit. Please fill in **ALL** blank areas on this form.

Please have the following information ready prior to calling your insurance company:

Patient's Name: _____ Policy Number: _____
 Subscriber's Name: _____ Certificate Number: _____
 Subscriber's Date of Birth: _____

The following information is required so that we can help you understand your dental benefit:

Annual Dental Benefit Maximum per patient: \$ _____
 Insurance Benefit used to date: \$ _____
 "Basic" Dental Treatment Maximum: \$ _____ at what percent _____%
 "Major" Dental Treatment Maximum: \$ _____ at what percent _____%
 Anniversary date of the policy: Calendar Year Benefit Year (Month: _____)
 Are benefits current with ODA Fee Guide? Yes No (Year: _____)
 Annual Deductible Amount: \$ _____
 Are white fillings on molars covered? Yes No

What is the percentage of insurance coverage for the following:

Diagnostic _____%
 What is the frequency of "Recall" Appointments? Every 6 months Every 9 months

Preventive _____%
 What is the number of scaling units covered per Benefit Year? _____

Restorative _____% Periodontal _____%
 Endodontic _____% Orthodontic _____% amount \$ _____ and Age Restriction: _____

Please bring the completed form to our office so that we can help you understand your dental benefit.