AILoopwise — AI implementation for independent dental practices

The Insurance Verification Call Sheet + the Denial-Prevention Checklist

Two working documents for the front desk: what to capture on every verification before treatment, and what to check before a claim leaves the practice — plus a triage system for the denials that still come back.

Free working document — keep it, print it, share it with your team. No signup required.

One sheet per patient, before treatment

Portal first, phone for the gaps — and record a reference number for every call. Re-verify before major treatment, not only at intake: plans change mid-year, and the verification that was true in January is the denial in July.

PATIENT		**DATE OF SERVICE**	
SUBSCRIBER NAME / DOB		**MEMBER ID / GROUP #**	
CARRIER + PHONE / PORTAL		**REP NAME / CALL REF #**	

COVERAGE BREAKDOWN

ITEM	ANSWER	NOTES / LIMITATIONS
Preventive %		
Basic %		
Major %		
Annual maximum — used / remaining		
Deductible — amount / met?		
Waiting periods (basic / major)		
Frequencies: prophy · BWX · FMX/pano		
SRP — coverage and per-quadrant rules		
Crowns — replacement clause (years)		
Missing-tooth clause		
Secondary insurance / COB order		
Ortho (if applicable): % / lifetime max / age limit		

> **If the plan is new to the office:** capture the fee schedule name, not just the percentages — the percentage of the wrong schedule is still the wrong number.
>
> **Downgrades:** ask specifically about posterior composite downgrades — it is the most common surprise on basic restorative.

Before the claim leaves — and when a denial comes back

A — BEFORE EVERY CLAIM GOES OUT

- [ ] Verification is current **for this treatment** — not just from intake
- [ ] Subscriber ID, DOB and carrier details match the card on file
- [ ] Attachments included where this carrier requires them — X-rays, perio charting, narratives for major work
- [ ] The narrative answers the carrier's actual question: why now, why this tooth, why this procedure
- [ ] COB order confirmed when two plans exist — primary first, every time
- [ ] Timely-filing window checked for this carrier — it is not the same for all of them

B — WHEN A DENIAL ARRIVES, PUT IT IN ONE OF FOUR BUCKETS

1 · Eligibility

Wrong plan, wrong ID, termed coverage. Correct the record and resubmit — fastest bucket to clear, first to check.

2 · Documentation

Missing attachment or narrative. Attach what was asked and resubmit — and note what this carrier wants for next time.

3 · Coding / frequency

Limitation, replacement clause, downgrade. Decide deliberately: appeal with documentation, or bill per plan and inform the patient.

4 · Timely filing

Appeal only with proof of the original submission. If the proof does not exist, the lesson is a process fix, not an appeal.

C — THE WEEKLY RHYTHM

- [ ] Run the aging report the same day every week — rhythm beats intensity
- [ ] Work the over-90 bucket first: the oldest claims are the ones about to expire
- [ ] Log every carrier call with date and reference number — an appeal without a paper trail is an opinion
- [ ] Tally denials by bucket for one month — the pattern tells you what to fix upstream

What we do with this at AILoopwise

We implement AI workflows for independent dental practices — and every engagement starts with a fixed-scope diagnostic on your practice's own claims and AR data. Aggregate numbers only, never patient records: we build inside your practice's systems, and your data stays there. The architecture is designed for HIPAA-regulated environments, and the diagnostic's result — the number — is yours to keep either way.

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