

The 2026 Dental Insurance Verification Kit

For Open Dental offices. The form, the call script, what changed in 2026, where to look for free, and how to set Open Dental up so the estimate is right before the patient sits down. Free from Dental Canvas — not affiliated with Open Dental Software or any insurance carrier. Checked against official sources on October 15, 2026 (sources at the end).

Why this kit exists. Half of verification is knowing what *isn't* on the breakdown: missing tooth clauses, frequencies, downgrades, waiting periods, history by tooth. Even the newest electronic eligibility rule (CAQH CORE vEB.2.1, June 2025) does not require payers to send most of those — so a portal printout or an electronic check can look complete and still burn you. This kit puts the questions that catch them on one page.

What's inside

- 1. The verification rhythm (7 days out + day before) — in Open Dental
- 2. The one-page verification form (front: basics · back: what the portal won't show you)
- 3. The rep call script — questions that force a specific answer
- 4. What changed in 2026 (CDT 2026, electronic eligibility, Medicare, Medicaid, Good Faith Estimates, state laws)
- 5. Free and no-fee carrier portals, payer IDs and timely filing limits
- 6. Open Dental setup: Insurance Verification List, frequencies, Insurance History, batch eligibility, and a copy-paste query
- 7. What to say to the patient (estimate wording)
- 8. Sources

1. The verification rhythm

When	What	In Open Dental
7 days before the appointment	Full verification for new patients, new plans, plans not verified this benefit year, and any treatment visit (crowns, SRP, implants, sedation). Fill the form. Get history for the codes on the schedule.	Appointment Lists › Ins Verify , set "scheduled appointment in 7 days." Mark Benefits Last Verified on the plan.
1 business day before	Eligibility only (still active? same plan?) for everyone on tomorrow's schedule. ADA guidance: eligibility can change without the plan being told; verify as close to the date of service as you can.	Mark Eligibility Last Verified (per patient). If you have clearinghouse eligibility, the Ins Batch Verify scheduled process can run this daily.
At check-in	"Has your insurance or your job changed?" Scan the card front and back if anything changed.	Update the plan before the patient is seated.
Medicaid patients	Every visit. From January 1, 2027, expansion adults move to 6-month renewals and retroactive coverage shrinks (federal law P.L. 119-21).	Use the separate Medicaid day filters in Insurance Verification Setup.

2. The verification form — front: the basics

Patient: _____ DOB: _____ Appt date: _____ Verified by: _____ Date/time: _____ Source: ☐ Portal
(screenshot saved) ☐ Electronic 271 ☐ Phone — rep: _____ ref #: _____

Subscriber & plan	Answer
Subscriber name / DOB / relationship to patient	
Subscriber ID · Group name and # (does it match the card and Open Dental?)	
Employer · Carrier · Plan name as the carrier states it	
Plan type: PPO · DHMO (capitation) · indemnity · Medicaid · Medicare Advantage · discount plan (not insurance)	
Is our office / this dentist in network for this plan's network?	
Effective date · termination date · active on the appointment date?	
Benefit year: calendar or plan year? Renewal month?	
Fully insured or self-funded (ERISA)? (State dental insurance laws often don't apply to self-funded plans.)	
Money	Answer
Deductible: individual / family — base and remaining . Waived for preventive?	
Annual maximum: individual / family — used and remaining . Separate maximum for implants or anything else?	
Coverage %: diagnostic · preventive · X-rays · fillings · endo · perio · oral surgery · crowns · bridges/dentures · implants · sedation	
Ortho: covered? % · lifetime max · used · age limit · how it pays (lump sum / monthly / quarterly)	
Other dental or medical coverage? Which is primary? (birthday rule for dependents; court decree overrides)	
Secondary's COB method: standard · non-duplication · carve-out. Does it need the primary EOB?	
Claims	Answer
Payer ID (primary and secondary) · paper claim address for this group	
Timely filing limit · how attachments are sent (which vendor)	
Pre-authorization or predetermination required for anything on the treatment plan?	

2. The verification form — back: what the portal won't show you

Ask these on every treatment plan. Most are **not** required in an electronic eligibility response, and many portals leave them out.

Ask	Answer
History by code: last date of service for every code on the schedule — exam, prophyl, perio maintenance, BWX, FMX/pano, fluoride, sealants, SRP by quadrant, crowns by tooth. And the next eligible date .	
Shared frequencies: Do D1110 and D4910 share a frequency or alternate? Do FMX and pano share? Do exam codes share?	
How frequency is counted: per benefit year · rolling 12 months · every X months · every X years	
Missing tooth clause? If yes, which teeth were missing before the effective date?	
Waiting periods by category — waived with proof of prior coverage?	
Downgrades / alternate benefit: posterior composites paid as amalgam? Porcelain or zirconia crowns on molars paid as metal? Implant paid as a bridge?	
Replacement rules: crowns, bridges, dentures, fillings — how many years/months before they'll pay again?	
Age limits: fluoride · sealants (which teeth) · ortho · dependent age-out	
Work in progress: crown prepped or ortho started before coverage began?	
Attachments required for SRP, crowns, buildups, implants? (Example: Delta Dental's 2026 policy for its CA/NY/PA group says SRP needs radiographs showing ≥2.0 mm loss of crestal bone height.)	
"Not billable to the patient" codes on this plan? (Example: Delta Dental treats new code D0461 cracked-tooth testing and D6196 as included in another procedure — you can't charge the patient.)	
New 2026 codes on the treatment plan (sedation D9244–D9247, D6049, D6280, D9936...) — covered on this group? If not covered, can we bill the patient?	
Exclusions: implants · TMD · night guards · sedation · cosmetic	
Medicare Advantage dental: this plan year's max, network, and does it pay through a debit card?	

3. The rep call script

Before you dial: have the subscriber ID, DOB, group #, the appointment date, and the CDT codes on the schedule. Ask by **code**, not by category — "Is D2740 on #30 covered?" gets a better answer than "Are crowns covered?"

1. "I'm verifying benefits for an appointment on **[date]**. Can I get your name and a **reference number** for this call?" (ADA guidance: record date, time and rep name.)
2. "Is the patient active on that date? What are the effective and termination dates?"
3. "Is this plan fully insured or self-funded?"
4. "Is our office in network for this group's network? Which fee schedule applies?"
5. "What's the deductible and how much is left? Individual and family. Is it waived for preventive?"
6. "What's the annual maximum and how much is left — and are there any claims in process that will use it?"
7. "For each of these codes — **[read codes]** — what's the coverage percentage, the frequency, and the **last date of service on file**? When is the next eligible date?"
8. "Do D1110 and D4910 share a frequency? Do FMX and pano share?"
9. "Is there a missing tooth clause? Any waiting periods? Any downgrades on posterior composites or crowns?"
10. "What's the replacement rule for crowns and bridges?"
11. "Does anything on this list need a predetermination or attachments?"
12. "Is there other coverage on file? What's the COB method?"
13. "What's the payer ID and the timely filing limit?"
14. Read back the key numbers. "So that's [x]% for D2740, frequency [x], last done [date], max remaining \$[x] — correct?"

Patient not found online but the patient says the rep confirmed coverage? Ask the patient to call the carrier and conference you in, or schedule them with a signed note that they're responsible until coverage is confirmed. Either way, save the reference number.

4. What changed in 2026

CDT 2026 (effective January 1, 2026)

- **60 changes:** 31 new codes, 14 revised, 6 deleted, 9 editorial (ADA). Claims for 2026 dates of service must use CDT 2026 codes.
- **Deleted:** D1352 (report as D2391 now), D1705, D1706, D1707, D1712 (COVID vaccine administration), D9248 (replaced by D9244–D9247). **Remove them from your Open Dental fee schedules and treatment plan templates.**
- **D2391** (1-surface posterior resin) no longer requires "into dentin" — it's used regardless of depth.
- **Sedation rebuilt:** new D9244 (minimal, single drug, enteral), D9245 (moderate, enteral), D9246/D9247 (moderate, non-IV parenteral), and D9224/D9225 (general anesthesia with advanced airway). The ADA publishes a free coding guide for these.
- **Most new codes aren't covered by standard plans** (examples from Delta Dental, Delta Dental of Kansas and UHC Dental documents). Several payers say a new code is covered only if its "reference code" is covered — e.g., sedation codes covered only if D9248 was.
- **D6049** (implant debridement, no flap): Delta Dental covers it only where implants are covered, 1 per tooth per 24 months, sharing the frequency with D6081.
- **Already approved for January 1, 2027 (CDT 2027):** 67 changes; D2390 composite crowns become reportable on any tooth (watch for posterior downgrade policy changes).

Electronic eligibility

- **CAQH CORE Eligibility & Benefits Data Content Rule vEB.2.1 (June 2025)**, built with the ADA and the National Dental EDI Council: when you ask about a specific CDT code, a CORE-certified payer must return frequency limits, waiting periods, age limits, max/remaining for that code and the **next eligible date**. Required for CORE certification — not a federal mandate yet, so many carriers still send thin data.
- Dental plans' fully electronic eligibility adoption **fell** from 82% to 80% (2025 CAQH Index). Plan on portals and phones for a while.

Medicare and Medicare Advantage

- **Traditional Medicare** pays for dental only when it's inextricably linked to covered medical care (for example, exams and infection treatment before an organ transplant or heart valve replacement, during head and neck cancer treatment, or before/during dialysis). Since July 1, 2025 these dental claims need the **KX modifier** and an **ICD-10 code**, and the medical–dental coordination must be documented.
- **Medicare Advantage** dental administrators are moving: Cigna's Medicare Advantage business moved to HCSC (sold as HealthSpring from January 2026) while Cigna Dental still administers the dental; UHC's dental network joins NationsBenefits Medicare Advantage plans for January 1, 2027. Verify on the website printed on the member's card.
- Medicare Advantage dental is plan-specific. Verify the max, network and payment method every plan year. For 2027, CMS requires supplemental-benefit debit cards to be plan-year-limited and rescinded the mid-year notice that reminded members about unused benefits — so patients will get fewer reminders from their plan.

Medicaid

- Federal law (P.L. 119-21): for ACA expansion adults, **6-month renewals** and **work requirements** start January 1, 2027, and retroactive coverage shrinks for applications from that date. Verify Medicaid eligibility at every visit.
- State examples: **Colorado** capped adult Medicaid dental at \$3,000/year from July 1, 2026 (emergency care and dentures excluded; signed disclosure needed before non-covered care — per the Colorado Dental Association). **California** delayed two Medi-Cal Dental cuts to July 1, 2027 (some older state notices still say 2026).
- The state's own system is the eligibility source of truth. Illinois tells offices DentaQuest's portal "is not the location to verify eligibility"; Arkansas says the MCNA member ID card "is not proof of eligibility."

Good Faith Estimates

- CMS confirmed to the ADA that **dentists must give Good Faith Estimates to uninsured and self-pay patients**. A patient with a stand-alone dental plan who chooses not to file, or whose plan doesn't cover the service, counts as self-pay.
- Timing: scheduled 3–9 business days out → within 1 business day; 10+ business days out → within 3 business days; and whenever a patient asks about cost. A bill \$400+ over the estimate can be disputed.
- Advanced EOBs for insured patients are **not** in effect yet.

State dental insurance laws

- The ADA counted 37 laws in 18 states in 2025 and 30 laws in 16 states by mid-July 2026: assignment of benefits, virtual credit card choice, network leasing consent, recoupment limits, dental loss ratio reporting. Examples with effective dates: Kentucky assignment of benefits (Jan 1, 2026), California virtual credit cards can't be the default (Apr 1, 2026), Indiana recoupment window cut to 180 days (Jul 1, 2026), Colorado network leasing consent (Aug 12, 2026), Maryland assignment of benefits (Jan 1, 2027).
- Most of these don't reach self-funded (ERISA) plans — which is why the form asks.

5. Carrier portals, payer IDs and timely filing

"Free" only where the carrier says so in writing; otherwise "no fee stated." Payer IDs only where an official carrier page shows them. Always confirm on the patient's card and the carrier's current manual — these change.

Carrier	Portal	Shows history / frequencies?	Cost	Payer ID	Timely filing (official)
Delta Dental (national)	Delta Dental Provider Tools (searches 39 Delta companies)	See portal	Free	Varies by Delta company (MI: DDPMI)	Delta Dental CA/NY/PA group: generally 12 months · Delta Dental of Michigan: 12 months
Delta Dental MI/OH/IN group	Dental Office Toolkit (DOT)	Yes — "complete dental history across all dental offices"	No fee stated	DDPMI (MI)	12 months
Cigna	CignaforHCP.com	Eligibility & benefits, 10 patients at once	No fee stated	62308	180 days from completion (dental guide) — and you can't bill the patient for a late claim. Cigna's general page says 90/180 days: file early
Aetna	Aetna Dental secure provider site	Eligibility & benefits, EOBs	No fee stated	60054 (DMO encounters 68246)	90 days after date of service (PPO guide)
Guardian	Guardian Anytime	Yes — coverage by CDT code with last visit details	No fee stated	64246	15 months
MetLife	MetDental (dentalprovider.metlife.com)	Eligibility, benefits, claims	No fee stated	Use the ID on the patient's card	Confirm with MetLife
UnitedHealthcare Dental	UHCdental.com	Yes — 8 years of utilization history, eligibility for a specific date	No fee stated	52133 (commercial)	90 days; adjustments 60 days from payment
Humana	Availity Essentials (Humana's only portal since May 2024)	Eligibility & benefits, claims	Free ("no cost to register")	73288	15 months commercial; 12 months Medicare

Principal	accounts.principal.com	Yes — tooth and service history, full breakdown PDF	No fee stated	61271	12 months (ortho 36)
Ameritas	Ameritas provider account	Yes — history, category frequencies & limitations	No fee stated	47009	Most group contracts: 90 days; appeals 180 days in most states
Sun Life	Sun Life provider portal	Claim status (confirm features)	—	70408	Confirm with Sun Life
Lincoln Financial	Lincoln DentalConnect	Eligibility, benefits, claim status	No fee stated	CX061	Confirm with Lincoln
DentaQuest	Provider Web Portal	Yes — service history	Free	State-specific	Illinois Medicaid: 180 days
LIBERTY Dental	i-Transact	Eligibility & benefits	Free	CX083	CA: no hard limit; encouraged within 45 days
MCNA (Medicaid)	portal.mcna.net	Historical activity	No fee stated	65030	Arkansas: 365 days
Blue Cross Blue Shield dental	Usually Availity Essentials (varies by Blue plan)	Varies	Free for plans that sponsor Availity	Varies	Varies

Clearinghouse eligibility: no major dental clearinghouse publishes a free all-payer tier (DentalXChange and Vyne quote prices; Availity Essentials is free only for sponsoring payers). **Rule of thumb:** when two carrier documents disagree on timely filing, file to the shorter one.

6. Open Dental setup that makes this stick

Insurance Verification List (Appointment Lists › Ins Verify)

- **Setup** (Insurance Verification Setup): appointments in the next 7 days; plan benefits not verified in 90 days (or this benefit year); patient eligibility not verified in 30 days; separate Medicaid day settings; tick **Always reverify service-year benefits** so plans re-list after renewal.
- Rows are **Pat** (eligibility, one patient), **Ins** (benefits, one row per plan so two people don't verify the same plan), or **Ins/Pat** (both). "01/01/0001" in Last Verified means never.
- Make your own statuses (Setup › Definitions › Insurance Verification Status): Left voicemail · Waiting on portal · Need history · Verified · Patient to call carrier.
- Version 25.4 added a date range and multiple-carrier filter to the list.

Put the answers where the estimate can use them

- **Benefits** (Edit Insurance Plan › benefits): benefit year, annual max (blank means Open Dental can't calculate remaining), deductible (blank means unknown, not zero), category %, waiting periods, age limits by code group.
- **Frequency limitations**: enter them per code group (Every # Years · # Per Benefit Year · Every # of Months · # in Last 12 Months). Open Dental warns at scheduling and its treatment plan estimates honor them.
- **Insurance History**: enter the last dates from the carrier (prophy, BWX, FMX/pano, exam, SRP by quadrant) so frequencies count work done at other offices. Since 25.1 there are two dates per category; 26.1 lets you customize the categories with code groups and set age limits by tooth.
- **Downgrades**: use substitution codes on the plan. **Not covered**: use the write-off override settings for exclusions, annual max and age/frequency.
- Mark **Benefits Last Verified** and **Eligibility Last Verified** with the Now buttons, so the list clears and the next person can see who verified and when.

Electronic eligibility (if you have a clearinghouse contract)

- Insurance Plan › **Request** pulls a 271; check the response group # against the plan (Open Dental shows a mismatch in red). Expect thin data from many carriers.
- The **Ins Batch Verify** scheduled process runs eligibility daily for the Pat rows on your list (carrier must be marked "trusted for real-time eligibility"; Open Dental Service must be running).

Copy-paste query: who still needs verifying

From our free Open Dental query pack (Query 5, read-only). Reports › User Query → paste → Submit Query. Lists everyone booked in the next 7 days whose eligibility or benefits were never verified or are more than 30 days old, with carrier phone, plan, group # and subscriber ID. Get all 12 queries: dentcanvas.com.

7. What to say to the patient

- **On every estimate:** "This is an estimate based on what your insurance told us on [date]. Your plan makes the final decision, and you're responsible for anything it doesn't pay."
- **Before care that may not be covered** (pano outside frequency, new 2026 codes, over the max): get a signed acknowledgment of the patient's portion before the procedure. (Check your state's rules and your contracts — some plans don't let you bill the patient for certain codes. This is not legal advice.)
- **Self-pay or not filing with a stand-alone dental plan:** give a Good Faith Estimate on the federal timeline above.

8. Sources (accessed October 15, 2026)

- ADA News: "60 changes coming to CDT Code in 2026" (June 2025); "New / Revised / Deleted CDT codes you should know for 2026" (Sept–Dec 2025); "67 changes coming to CDT 2027" (Apr 14, 2026); "37 dental insurance reform laws passed in 2025" (Oct 10, 2025); "State dental insurance reforms continue momentum in 2026" (Jul 16, 2026); "ADA receives clarification on No Surprises Act" (Feb 2023).
- ADA: Eligibility Verification; Dental Plans – Coordination of Benefits; 2024 ADA Dental Claim Form and completion instructions; CDT Coding Guide: Nitrous Oxide, Sedation and General Anesthesia (Jan 2026).
- Delta Dental, "CDT 2026 updates" provider summary (#704328.03, 10/25); Delta Dental of Kansas, CDT 2026 Procedure Code Changes (11/25); UHC Dental, Annual CDT code changes (12/12/2025).
- CAQH CORE Eligibility & Benefits (270/271) Data Content Rule vEB.2.1 and Appendix (June 2025); 2025 CAQH Index.
- CMS: Medicare Dental Coverage (modified Mar 10, 2026); Transmittal 13096 / CR 13649; CY2026 and CY2027 MA/Part D final rule fact sheets; CMS Good Faith Estimate FAQ; No Surprises Act Toolkit (June 2026). CMCS Informational Bulletin on P.L. 119-21 (Nov 18, 2025); SMD #26-001 (Mar 6, 2026).
- California DHCS 2026-27 Budget Act Highlights (Jul 1, 2026); Colorado Dental Association, July 1 changes (Jun 18, 2026); Illinois HFS Dental Office Reference Manual (Sept 2026).
- State laws: Colorado HB26-1070; Maryland SB 813 (2026); Kentucky HB 210 (2025); Indiana HEA 1271 (via Indiana Dental Association); California SB 386 (via CDA); Mississippi Insurance Dept. Bulletin 2026-8.
- Carrier documents: Cigna DPPO Dental Office Reference Guide (12/25); Aetna Dental Office Guide (rev. 09/25/2026) and electronic claim FAQs; Guardian Anytime guide (2025) and claim filing flyer (2026); Humana Dental Provider Manual (12-25); UHC National PPO & Medicare Provider Manual (rev. 12/10/2025); Principal "Working with us"; Ameritas dental provider pages and Classic Network Provider Guide (AM 668 5-26); Delta Dental "Avoid late claim submission"; UHCdental user guide (Jul 30, 2026); Humana Q2 2024 provider newsletter; Sun Life claim submission tips (09/24); Delta Dental of Michigan Welcome booklet (07.26); DentaQuest VA newsletter (June 2026); LIBERTY CA Provider Reference Guide (June 2026); MCNA/AFMC Arkansas deck (2023); MetDental sign-in page; UHC/DBP Client Portfolio Reference Guide (02/18/2026).
- Open Dental Manual (v24.4): Insurance Verification List and Setup, Insurance Plan, Benefit Information, Frequency Limitations, Insurance History, Electronic Eligibility and Benefits, Scheduled Processes; Open Dental release notes 25.1–26.1; Open Dental Fees (Feb 2, 2026).

This kit is general information for dental office staff, not legal or billing advice. Plans differ — the carrier's own documents for the patient's plan always win. Dental Canvas sits beside Open Dental and shows each person in the office what's next; it never changes anything in Open Dental. dentcanvas.com