Medical Insurance Verification

Patient Information

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Patient Name

____
Patient Address

____
City ST Zip

______________ ______________
Home Phone No Work Phone No

______________ ______________
Social Security No Date of Birth

M _____ F_____

Diagnosis:

_____ _____ _____ _____ _____ _____
Applicable ICD-9-CM Diagnosis code(s)

_____ _____ _____ _____ _____ _____
Anticipated CPT Code(s) for Procedure(s):

Patient Insurance Information

____
Primary Insurance Co Policy No Group No

____
Primary Insurance Phone No

____
Subscriber's Name Date of Birth

____
Subscriber's Relationship to Patient

____
Secondary Insurance Co Policy No Group No

____
Secondary Insurance Phone No

____
Subscriber's Name Date of Birth

____
Subscriber's Relationship to Patient

Patient Eligibility and Benefits Information

Effective Date of Coverage: ______________

Coverage Terminated? Yes ☐ No☐ Date: ______________

Plan Type: ☐HMO ☐PPO ☐POS Other: ______________

In-Network Benefits: $ ______________
Co-Payment

$ ______________ Has Deductible Been Met?
Deductible Yes ☐ No ☐

$ ______________ $ ______________
Co-insurance Other Out-of-Pocket Expense

Benefits for Treatment? Yes ☐ No ☐

Is a Referral Necessary? Yes ☐ No ☐

Is Prior-Authorization Required? Yes ☐ No ☐

Out-of-Network Benefits? Yes ☐ No ☐
Out-of-Network Financial Responsibilities? Yes ☐ No ☐

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Insurer Information

Call Date: ______________ Time of Call: ______________

____
Name of Insurance Rep Phone No / Ext

____
Prior-Authorization Phone No Fax No

____
Prior-Authorization Contact Name

____
Prior-Authorization Approval No

____
Referral Phone No Fax No

____
Referral Contact Name

Notes:______________________________

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