INSURANCE VERIFICATION FORM

To be completed by patient:

Date: _____

Patient Legal Name: _____ Date of Birth: _____
(As it appears on card)

Member Name:_____ Date of Birth:_____
(As it appears on card)

Relationship to Member Insured: *(Circle One)* Self Spouse Child

Last 4 digits of Member's Social Security No.: _____

Insurance Company: *(Circle One)*

Aetna Blue Cross/Blue Shield Cigna PPO United Healthcare

Insured ID#: _____ Insured Group/Employer: _____

Home Address:

_____
(Street) *(City)* *(State)* *(Zip)*

I, _____ ***(Patient name if over 18 yrs.)*** **verify that the information stated above is correct and that I will be responsible for any charges that my insurance company, _____, does not cover. This may include co-payments, charges over the "allowed amount," procedures, eyewear or lens materials that are not covered under my insurance policy.**

_____
Patient's Signature/Guardian Date

To be completed by provider:

Circle One: Routine Eye Coverage Medical Eye Coverage

Effective Date: _____

Life Maximum: _____ Deductible: _____ Ded.Used: _____

Patient Co-Pay: _____ Insurance Pays: _____%

Hardware Benefits:

CL Evaluation Coverage: _____

Verified By: _____ Cust. Service Agent: _____