Sample Insurance Verification Form

Patient Information

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 ☐

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: _____