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PATIENT INSURANCE COVERAGE VERIFICATION FORM

Prior to scheduling your "procedure" with us, please contact your insurance company to find out the following details regarding your particular benefit coverage and/or financial responsibility for the services you desire.

We have provided all of the information your insurance company may require.

Patient: _____ Birth date: _____

Insurance Company: _____ Member I.D. # _____

Ask your insurance company what your coverage is for the following **IN OFFICE** procedure :

PROCEDURE	PROCEDURE CODE	DIAGNOSIS CODE
ESSURE (In office tubal sterilization)	58565	Z30.2
NEXPLANON (birth control implant)	J7307	Z30.49
NEXPLANON INSERTION	11981	Z30.49
IUD INSERTION	58300	Z30.430
PARAGARD IUD	J7300	Z30.430
LILETTA IUD	J7297	Z30.430
MIRENA IUD	J7298	Z30.430
SKYLA IUD	J7301	Z30.430
NOVASURE (in office endometrial ablation)	58563	N92.4

Do you have a **co-insurance** for this service? yes (if so, how much - _____%) no

Do you have a **co-payment** for this service? yes (if so, amount - $ _____) no

Do you have a **deductible** that must be met first: yes (if so, how much - $_____) no

If you are inquiring about a contraceptive device, circle which kind of device benefit it is: **Medical Pharmacy Both**

I spoke with _____ Date:_____ Time: _____

Call Reference # _____

Please mail, fax (410-337-9005) or email susienchungmd@gmail.com prior to your appointment.