

Medical Insurance Verification

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: _____

