**MEDICAL INSURANCE VERIFICATION FORM**

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| **PATIENT INFORMATION** |

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Sex**: [ ]  Male [ ]  Female

**Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_ **Street Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ZIP Code**: \_\_\_\_\_\_\_\_

**SSN**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **E-Mail**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ICD‐9‐CM Diagnosis Code(s)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Anticipated CPT Code(s) for Procedure(s)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **INSURANCE INFORMATION** |

**Insurance Provider**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy No.**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group No.**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Policy is**: [ ]  Primary Insurance [ ]  Secondary Insurance

**Subscriber Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_

**Subscriber Relationship to Patient**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **ELIGIBILITY AND BENEFITS** |

**Coverage Start Date**: \_\_\_\_\_\_\_\_\_\_\_ **Coverage End Date**: \_\_\_\_\_\_\_\_\_\_\_

**Plan Type**: [ ]  HMO [ ]  PPO [ ]  Medicare [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Deductible**: $\_\_\_\_\_\_\_\_\_\_ **Has Deductible Been Met?** [ ]  Yes [ ]  No

**Copayment**: $\_\_\_\_\_\_\_\_\_\_ **Coinsurance**: \_\_\_\_% **Out-of-Pocket Limit**: $\_\_\_\_\_\_\_\_\_\_

**Benefits**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Referral Necessary?**........................................ | [ ]  Yes [ ]  No |
| **Prior Authorization Required?**....................... | [ ]  Yes [ ]  No |
| **Out-of-Network Coverage?**............................. | [ ]  Yes [ ]  No |

**Out-of-Network Financial Responsibilities**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **INSURER INFORMATION** |

**Verification Date**: \_\_\_\_\_\_\_\_\_\_\_ **Verification Time**: \_\_\_\_ [ ]  a.m. [ ]  p.m.

**Insurance Rep.**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone / Ext.**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prior Auth. Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Fax**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prior Auth. Contact**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Approval No.**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Fax**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral Contact**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notes**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Signature**: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](http://esign.com/) Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_