# MEDICAL INSURANCE VERIFICATION FORM

## 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)**: _____

## 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**: _____

## 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**: _____
**Referral Necessary?**..... ☐ Yes ☐ No
**Prior Authorization Required?**..... ☐ Yes ☐ No
**Out-of-Network Coverage?**..... ☐ Yes ☐ No
**Out-of-Network Financial Responsibilities**:

## 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**:

**Signature**: _____ Print Name: _____