

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 & BENEFITS INFORMATION

Effective Date of Coverage: _____

Coverage Terminated? Yes ☐ No ☐ Date: _____

Plan Type: ☐ HMO ☐ PPO ☐ POS Other: _____

In-Network Benefits: \$ _____

Co-Payment
\$ _____ Deductible
Has Deductible Been Met?
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: _____
