

# 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

\$ \_\_\_\_\_ 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_