Insurance Verification Form

Patient Name: ______________________________ DOB: __________ Date: ___________

Primary Insurance: ___________________
Policy #: ______________________________
____
Subscriber's Name (If different)
Are We In Network? ____Yes _____No
Is prior doctor's referral required?___ Yes ___ No
Is Prior Authorization Required? ____Yes ____ No
Effective date of coverage: _________________

Primary In Network Benefits: Copay: $____ per visit
Deductible: _________ Amount Met: ___________
Out of Pocket: _______ Amount Met: ____________
Plan Pays: _________ % Patient Pays __________%
Limits/Special Requirements: _________________
____
**MEDICARE ONLY: HH or Hospice _____ TPL _____
Dates Enrolled ____________

Secondary Insurance: _________________
Policy #: ______________________________
____
Subscriber's Name (If different)
Are We In Network? ____Yes _____No
Is prior doctor's referral required?___ Yes ___ No
Is Prior Authorization Required? ____Yes ____ No
Effective date of coverage: _________________

Secondary In Network Benefits: Copay: $____ per visit
Plan Type: _ HMO _PPO _POS other: ____________
Deductible: ___________ Amount Met: __________
Out of Pocket: __________ Amount Met: _________
Plan Pays: _________ % Patient Pays ___________%
Limits/Special Requirements: __________________
____

Out of Network Benefits: Co-pay: $_______ Deductible: ___________ Amount Met: __________
Out of Pocket: __________ Amount Met: ________ Plan Pays: ________ % Patient Pays __________%
Limits/Special Requirements: ____

Prior-Authorization Information:
Prior-Auth Phone No________________________ Prior-Auth Fax No: ________________________

Spoke with ____________________________________ Call Ref #___________________________

Date: ________________________________ Time: ___________________________________

______________________ Went over my insurance benefits with me.

I understand that I am [___in network ___ out of network] and fully understand my insurance coverage.

Patient Signature: _________________________________ **Date:** ________________