Insurace Verification Form

CIRCLE ONE **DATE VERIFIED: _____ VERIFIED BY: _____**

INSURANCE COMPANY: PRIMARY or SECONDARY

KIND OF INSURANCE: PPO POS IPA MEDI SUPPLIMENT

LAST NAME:_____ FIRST NAME:_____ PT # _____

HOME PH#_____ WORK PH#_____ OTHER PH# _____

ST. ADDRESS:_____ SS # _____ BIRTHDAY_____

CITY: _____ STATE_____ __ ZIP _____ DRIVERS LC #_____

OCUPATION: _____ STATUS:_____ SEX: _____

EMPLOYER: _____ DOI : _____ CLAIM # _____

CONTACT IN CASE OF EMERGENCY _____ REFFERED BY: _____

INSURANCE COMPANY: _____ ID/MEMBER: _____
ADDRESS TO MAIL CLAIMS: _____ GROUP: _____
_____ POLICY: _____
TEL: _____ FAX :_____ CLAIM: _____
CONTACT PERSON:_____

MEDICAL COVERAGE YES / NO EFFECTIVE DATE: _____
DEDUCTIBLE START DATE: _____
OFFICE VISIT CO-PAYMENT: $_____ AMOUNT OF DEDUCTIBLE: $ _____
NON OFFICE VISIT COVERAGE (Diagnosis inspection): $_____SUBJECT TO DEDUCTIBLE: Y / N
HAS THE DEDUCTIBLE BEEN MET? Y / N IF NOT, HOW MUCH HAS BEEN MET: $ _____

ACUPUNCTURE COVERAGE: Out of network : Y / N
OUT OF NETWORK: NUMBER VISITS PER YEAR _____ AMOUNT PAID PER VISIT _____
MAXIMUM PAID BENEFITS PER YEAR: $_____ HAS THE PATIENT USED THE BENEFITS: $_____
SUBJECT TO DEDUCTIBLE: Y / N (Code 98941)

IS THERE A LIMIT TO THE NUMBER OF MODALITIES PER VISIT: _____ (IF YES, HOW MANY)

DO WE NEED PRE-AUTHORIZATION FOR MRI/CT SCAN IF REFERRED BY A SPECIALIST: Y / N

NOTES:

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