INSURANCE VERIFICATION FORM

REMAINING DEDUCTIBLE AMOUNT:._____

COPAY: _____ COINS:._____ VIRTUAL: _____

PATIENT NAME: _____ CHART#: _____

DATE OF BIRTH: _____

RENDERING PROVIDER: _____

PRIMARY INS NAME: _____ SECONDARY INSNAME:._____

PHONE NO:._____ PHONE NO:_____

ID NO:._____ ID NO:_____

EFFECTIVE DATE:._____ TERMDATE: _____

IND. DEDUCTIBLE:_____ MET:._____

FAMILY DEDUCTIBLE:_____ MET:_____

PLAN YEAR OR CALENDAR YR OED: _____

MEDICARE ONLY: DOES SECONDARY COVER ANNUAL OED: _YES ___ NO

IND OOP:_____ MET:_____

FAMILY OOP:_____ MET:_____

COPAY: COINS:_____

PLAN TYPE: HRA: _____

ISAUTHORIZATION OR REFERRAL REQUIRED:._____

VIRTUAL BENEFITS: _____

PAYER ID: _____

CLAIMS MAILING ADDRESS: _____

_____

LAST EOB DATE(S) CHECKED: _____

REP NAME:._____ REFERENCE NO:._____

COMPLETED BY:_____ DATE:._____

COMMENTS:

_____

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