Practice Logo

Practice Name
Street Address
City, State Zipcode

Insurance Verification

_______Primary Carrier
_______Secondary Carrier

_______Worker's Compensation
_______COBRA

_______Other

Patient Name: ______________________ **Date:** ______________ **Time:** __________

Date of Birth: ______________________ **SSN:** ______________________

Therapy: ______________________ **Diagnosis:** ______________________

ICD-9-CM Code(s): ______________________

Insured: __________ **Relationship:** __________ **Employer:** ______________________

Policy Number: ______________________ **Group Number:** ______________________

Insurance: ______________________ **Phone:** ______________________

Contact: ______________________ **Agent#/Call Ref#** ______________________

Address: ______________________ **City, State, Zip:** ______________________

CID In Network: __________ **Self-funded:** __________ **HMO, PPO, POS, Indemnity, MCR Supp Only:** __________

Effec Date: __________ **Current?** __________ **Term Date:** __________ **COBRA Current:** ______

Pre-Existing (if less than a year): ______________ **Pre-certification/determination required:** __________

Case Manager: ______________________ **Phone:** ______________________

BENEFITS:

$__________Deductible per ______________ $__________ met Included in OOP? __________

__________% Paid to $__________ OOP or Chgs $__________ met Inpatient or Outpatient: __________

__________% Paid to $__________ Lifetime Max $__________ met

Specialist Office Visit Co-pay: $______________ **Pay 100% after OV co-pay?** ______________

PCP: ______________________ **Phone #:** ______________________

Spoke to: ______________________ **Referral Requested:** ______________________

NOTES: ____

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Implemented on: 1/1995	Revised Date: 03/2006