

Sample Insurance Verification Form

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

\$ _____ Has Deductible Been Met?
 Deductible 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: _____

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