INSURANCE VERIFICATION FORM

PATIENT NAME:_____ **DOS:**_____

DOB:_____ **SS#:**_____

PRIMARY INSURANCE

POLICY HOLDER'S NAME:_____

INSURANCE NAME:_____

INSURANCE PHONE#:_____

INSURANCE ADDRESS:_____

CITY, STATE, ZIP_____

ID#:_____ **GROUP#:**_____

EFFECTIVE DATE:_____ **TERM DATE:**_____

IN NETWORK

COPAY AMOUNT:_____

DEDUCTIBLE AMOUNT: $**\_\_\_\_\_ **APPLIED AMOUNT:$_____

OUT OF POCKET AMOUNT: $**\_\_\_\_\_ **APPLIED AMOUNT:$_____

50/50 55/45 60/40 65/35 70/30 75/25 80/20 85/15 90/10 100%

PRECERT REQD Y N PRE EXISTING Y N LTM:_____

PRECERT #:_____ **AUTHORIZATION Y N**

OUT OF NETWORK

DEDUCTIBLE AMOUNT:$**\_\_\_\_\_ **APPLIED AMOUNT:$_____

OUT OF POCKET AMOUNT:$_____ **APPLIED AMOUNT:**_____

50/50 55/45 60/40 54/35 70/30 75/25 80/20 85/15 90/10 100%

PRECERT REQ Y N PRE EXISTING Y N LTM: _____

PRECERT#:_____ **AUTHORIZATION Y N**

Spoke with:_____ **Date:**_____