VERIFICATION OF INSURANCE COVERAGE

1. Patient Information

Name: ______________________ Patient/Chart # ______________

Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

2. Insurance Type *(check those that apply)*

SELF INSURANCE (CONSUMER DIRECTED)

- ❑ Health Savings Account (HSA)
- ❑ Personal Health Insurance (not sponsored by employer)
- ❑ Other

EMPLOYER SPONSORED (PRIVATE SECTORS)

- ❑ Group Health Insurance
- ❑ Self-Funded Benefit Plan
- ❑ Private Schools

GOVERNMENTS (PUBLIC SECTORS)

- ❑ Medicare
- ❑ Medicaid
- ❑ Municipal (city, state, etc.)
- ❑ Public School

OTHER TYPES

- ❑ Personal Injury
- ❑ Workers Comp.
- ❑ Church

3. Insurance Payer Information

Carrier Name: ______________________

Contact Name: ______________ Fiduciary: ______________

Phone # ______________ Fax # ______________

❑ Employee of Insurance Company ❑ Administrator ❑ Other: ______________

4. Insured Information (Policy Holder)

Name: ______________ ID# ______________

Policy Name and/or #______________ Group # ______________

5. Coverage Details

Panel Provider? ❑ Yes ❑ No
If no, out of panel provision? ❑ Yes ❑ No

Pre-authorization? ❑ Yes ❑ No
If yes, #______________

Deductible (calendar/fiscal) $ __________
Met? ❑ Yes ❑ No

Co-pay? ❑ Yes ❑ No If yes, Amount $ __________

Visit limits per (calendar/fiscal) year _________
Met? ❑ Yes ❑ No remaining visits _______

Fee Schedule Available? ❑ Yes ❑ No

Exclusions/Limits? ______________

Diagnoses: ______________

Procedures: ______________

Other info: ______________

6. Claims Information

Accept CMS-1500? ❑ Yes ❑ No

Mail Claims to: attn: ______________
at: ______________
____

Fax Claims to: ______________

Electronic Claims to: ______________
____

Special Reports Needed? ❑ Yes ❑ No

If yes, when? ______________

Turnaround Time? ______________

Other info: ______________
____

7. Coverage Reverification

Date ___/___/___ Spoke to: ______________

Changes?______________

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