Insurance Verification

Patient Name: ____ Patient ID #: ____________________

Patient Date of Birth: _______/_______/_________

Insurance Company: ____

Claims Mailing Address: ____

Insurance Company Phone #: ____

Member ID #: ____ (Prefix & Suffix)

Group #: ________________________________ Payor ID #: ________________________________

Policy Holder's Name: ____

Policy Holder's Relationship to Patient: ____

Pay Provider In Network ☐ Yes ☐ No

In Network Benefits:

Copay _______________ Co-Insurance _______________ Deductible _______________

Limited Benefits:

Office visits per year: _______________

Maximum payment for office visit: _______________

Maximum payment for diagnostic tests: _______________

Deductible: _______________

Co-Insurance: _______________

Copay: _______________

Is there a total maximum payment for each year? ☐ Yes ☐ No

If yes, what is the total maximum? _______________

****WE DO NOT ACCEPT DISCOUNT PLANS****

Verified By: ____ Date Verified: ______________________

Insurance Representative Name: ____

Call Reference #: ____

SCAN INTO PATIENT'S ELECTRONIC MEDICAL RECORD