

Insurance Verification Form

<b>CIRCLE ONE</b>	<b>DATE VERIFIED:</b> _____	<b>VERIFIED BY:</b> _____
INSURANCE COMPANY: _____ PRIMARY or SECONDARY		
KIND OF INSURANCE: _____ PPO POS IPA MEDI SUPPLIMENT		
LAST NAME: _____ FIRST NAME: _____ PT # _____		
HOME PH# _____ WORK PH# _____ OTHER PH# _____		
ST. ADDRESS: _____ SS # _____ BIRTHDAY _____		
CITY: _____ STATE _____ ZIP _____ DRIVERS LC # _____		
OCCUPATION: _____ STATUS: _____ SEX: _____		
EMPLOYER: _____ DOI: _____ CLAIM # _____		
CONTACT IN CASE OF EMERGENCY _____ REFERRED BY: _____		
INSURANCE COMPANY: _____		ID/MEMBER: _____
ADDRESS TO MAIL CLAIMS: _____		GROUP: _____
_____		POLICY: _____
TEL: _____ FAX: _____		CLAIM: _____
CONTACT PERSON: _____		
<b>MEDICAL COVERAGE</b> YES / NO EFFECTIVE DATE: _____		
DEDUCTIBLE START DATE: _____		
OFFICE VISIT CO-PAYMENT: \$ _____ AMOUNT OF DEDUCTIBLE: \$ _____		
NON OFFICE VISIT COVERAGE (Diagnosis inspection): \$ _____ SUBJECT TO DEDUCTIBLE: Y / N		
HAS THE DEDUCTIBLE BEEN MET? Y / N IF NOT, HOW MUCH HAS BEEN MET: \$ _____		
<b>ACUPUNCTURE COVERAGE:</b> Out of network : Y / N		
OUT OF NETWORK: NUMBER VISITS PER YEAR _____ AMOUNT PAID PER VISIT _____		
MAXIMUM PAID BENEFITS PER YEAR: \$ _____ HAS THE PATIENT USED THE BENEFITS: \$ _____		
SUBJECT TO DEDUCTIBLE: Y / N ( Code 98941 )		
IS THERE A LIMIT TO THE NUMBER OF MODALITIES PER VISIT: _____ (IF YES, HOW MANY)		
DO WE NEED PRE-AUTHORIZATION FOR MRI/CT SCAN IF REFERRED BY A SPECIALIST: Y / N		
<b>NOTES:</b>		
_____		
_____		
_____		
_____		
_____		
_____		