INSURANCE VERIFICATION FORM DATE:_____

NAME OF DOCTOR _____ IN-NETWORK Y N

NAME OF CARRIER_____ PHONE_____

NAME OF PATIENT _____ DOB _____

NAME OF INSURED _____ DOB____ _____

NAME OF CUSTOMER SERVICE REP _____

TIME OF CALL: _____ **REFERENCE NUMBER** _____

1. Is policy in effect? Y N
2. Effective date of policy? _____
3. Is policy written for a calendar or fiscal year? CAL FY
4. If FY policy, give dates START _____ END _____
5. Does this policy cover _____ (name of specialty, ex: chiropractic, dermatology, ophthalmology, etc.) **SKIP THIS QUESTION IF FAMILY PRACTICE, GENERAL PRACTITIONER.**
6. Does the patient have a deductible to meet? Y N **(if NO, skip to #10)**
7. If yes, is the deductible an Individual or Family deduct? Ind Fam
8. If yes, how much is the deductible? $_____
9. How much of the deductible has been met for the plan year? $_____
10. Does the patient have a coinsurance (pays a % of fee) Y N **(if NO, skip to #12)**
11. If yes what is the patient's coinsurance? _____%
12. Does the patient have a co-pay (fixed $ amount per visit)? Y N
13. If yes, what is the co-pay? $_____
14. What is the patient's Out-of-pocket max? $_____ Met? _____

(**FAMILY/GENERAL PRACTICE CLINICS OR PROVIDERS SKIP TO #17)**

15. Are there any limitations on (name of specialty) services? Y N
16. If YES,
    a. Number of Visits _____ Number of Visits used _____
    b. $ Amount per cal/FY $_____ Amount used $_____
    c. $ Amount per day (Daily capitation/global fee) $_____
    d. Procedures per day _____
    e. CPT CODES: (if your specialist performs certain procedures routinely, ask the claims representative to check those specific CPT codes- customize your form HERE with those codes
17. Is preauthorization required for services? Y N
18. If yes, provide details of preauthorization requirements

_____

MAILING ADDRESS TO SEND CLAIMS _____

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