INSURANCE VERIFICATION FORM

DATE:_____

NAME OF PROVIDER _____ IN-NETWORK Y N

NAME OF CARRIER_____ PHONE_____

NAME OF PATIENT _____ DOB _____

NAME OF INSURED _____ DOB____ _____

POLICY NUMBER _____ GROUP _____

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 Mental Health Services? Y N
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? _____
15. Are there any limitations on Mental Health 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 _____
17. Is preauthorization required for services? Y N
18. If yes, provide details of preauthorization requirements

_____

_____

_____

MAILING ADDRESS TO SEND CLAIMS _____

_____

MISC/ADDITIONAL INFO ON BENEFITS:_____

_____

New Patient_____ Established Patient New Insurance _____ Reverification Existing Policy _____

Verified by _____