Appointment Date:

Insurance Verification

Date:____________________

Initials:__________________

☐ Primary
☐ Secondary
☐ Third

How is primary determined? ____________

Patient Name_______________________________

Patient DOB________________________________

Insured Name_______________________________

Insured DOB________________________________

Insured's Relationship to Patient _______________

Insured ID #_______________________________

Employer__________________________________

Ins. Company_______________________________

PPO DMO HMO PDP PPO+Premier Other

Address___________________________________

____

____

Phone #___________________________________

Insurance Payer ID #__________________________

Group #___________________________________

Office Address:

____

____

Tax ID#______________ NPI#______________

Preferred Provider: Yes No

Lifetime Max__________________________

Lifetime Max Used_____________________

Yearly Max: N/A Yes No

Yearly Max: __________________________

When does Yearly Max Renew? _________

Deductible_________Yearly_____________

% Paid______________________________

Effective Date_________________________

Waiting Period________________________

Age Limit_____________________________

Coord. of Benefits: Standard Non-Dup

Preauthorization Required? Yes No

Pmts: Monthly Qtrly Semi-Annual Annual

Continuation Forms: Submit or Automatic

% Paid at Banding _______________________

Is Work in Progress Covered? Yes No

Out Of Network Benefit:__________________

Spoke With_____________________________