**Insurance Verification Information Form**

Insurance carrier require specific information to process and assure payment for claims review by our billing department. If this is not filled out, and your insurance denies payment due to commission of this information, then you will be responsible for the charges incurred. Thank you for your cooperation.

Date\_\_\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Account #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insured Party: ( if different from the patient)**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex: M or F SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (For appointment reminders)

**Insurance Information ( Office use only)——————————————————————————————**

Primary Ins Co:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ins claim adjust/verifier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy effective Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID or Claim #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Verify Date:\_\_\_\_\_\_\_\_Auth#\_\_\_\_\_\_\_\_\_\_\_\_\_\_#of visits approved:\_\_\_\_Auth Exp Date:\_\_\_\_\_\_\_

Deductible: Single $\_\_\_\_\_\_\_\_\_\_\_ Met $\_\_\_\_\_\_\_\_\_\_\_Family $\_\_\_\_\_\_\_\_\_ Met $\_\_\_\_\_\_\_\_\_\_

OOP: Single $\_\_\_\_\_\_\_\_\_\_\_\_\_Met $\_\_\_\_\_\_\_\_\_\_\_Family $\_\_\_\_\_\_\_\_\_\_Met $\_\_\_\_\_\_\_\_\_\_\_\_\_

Deductible Included in OOP amount? Yes No DME\_\_\_\_\_\_\_\_\_\_\_

Patient Percentage:\_\_\_\_\_\_\_\_Or Co-Pay\_\_\_\_\_\_\_\_\_\_\_\_\_ Script Req? Yes or No

Max visits:\_\_\_\_\_\_\_\_\_\_\_\_\_#of Visits used:\_\_\_\_\_\_\_\_\_\_ Max $ Amount Allowed\_\_\_\_\_\_\_\_\_\_\_\_

RX Required: Yes or No ACN Cert: Yes or No

Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondly Insurance Information ( Office use Only)**

Secondary Ins. Co:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ins claim adjuster/verifier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy effective Date:\_\_\_\_\_\_\_\_\_\_\_\_

Insured Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_ M or F

ID or Claim #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group Name:\_\_\_\_\_\_\_\_\_\_\_

Deductible: Single $\_\_\_\_\_\_\_\_\_\_ Met $\_\_\_\_\_\_\_\_\_ Family $\_\_\_\_\_\_\_\_ Met $\_\_\_\_\_\_\_\_\_

OOP: Single $\_\_\_\_\_\_\_\_\_\_\_\_Met $\_\_\_\_\_\_\_\_\_\_\_Family $\_\_\_\_\_\_\_\_\_\_\_\_Met $\_\_\_\_\_\_\_\_\_\_\_\_

Deductible Included in OOP amount? Yes No Visits Allowed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Percentage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Or Co-Pay\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rx? Yes or No

Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_