INSURANCE VERIFICATION FORM

Update ☐ New ☐

Patient Name:_____ ID/SSN #:_____

Patient Insurance ID (if different from above)_____Group Policy #_____

Insurance Company:_____

Primary Insurance?_____ Secondary?_____ Tertiary?_____

Authorization/referral #_____ Name of Contact_____

Date/Time of Auth:

_____

Phone/Fax/Address for Auth:_____

Effective Date:_____/_____/_____ PCP:_____ Tel #_____

Prescription Drug Benefit: ❑ Yes ❑ No
Deductible_____

Specific Pharmacy Requirement: _____❑ Mail order

Co-insurance/Co-pay:_____ Cap for drugs or diagnosis: $_____

Pre-existing?_____ Until when?_____ % worked for eligibility_____

Catastrophic Coverage or Stop-loss_____ When?_____

Medicare? Card Number:_____ Effective:____/____/____

❑ Part A ❑ Part B Medicare HMO?_____

Medicare Supplement? ❑ Yes ❑ No Medigap Plan?_____

Does policy cover Deductible? ❑ Yes ❑ No Coinsurance? ❑ Yes ❑ No

Prescription Drugs? ❑ Yes ❑ No

_____

Medicaid? ❑ Yes ❑ No Pending?_____ Spend Down? ❑ Yes ❑ No

Share of Costs?_____ Spend Down Amount $_____

How is cost of drugs affected?_____

Hospice Benefits Enacted?

_____

Comments_____

_____

_____

_____

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Conclusion: ❑ Patient Has Coverage ❑ Patient Has No Coverage ❑ Research Necessary