

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 _____

Conclusion: Patient Has Coverage Patient Has No Coverage Research
Necessary