INSURANCE VERIFICATION

Date Verified ____

Patients Name: ____

Member ID # ____

Insurance Company: ____

Insurance Network: ____

Insurance Company Phone # __________________________________

Spoke with: ____

Date Insurance Effective: ____________________________________

Deductible: ___No ___Yes Has the Deductible Been Met? ___No ___Yes

Claims Paid At: ______________________

CoPay: ____________________________

Maximum Limit: _____________________

Per: ___Calendar Year ___Plan Year

Parity Apply: ___No ___Yes

Need Auth: ___No ___Yes Authorization Phone #: _______________

Paper Claims Sent to: ____
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