

Insurance Verification Form

Collect and document full eligibility and benefit details at the time of verification

Complete this form when verifying insurance prior to or at the time of service. Verify all benefits directly with the payer — coverage verification is not a guarantee of payment.

VERIFICATION DETAILS

Date Verified:

Verified By:

Payer Phone (Provider Line):

Call Reference / Rep Name:

Verification Method: Phone Portal EDI 270/271 Other

PATIENT INFORMATION

Patient Name:

Date of Birth:

Address:

Phone:

PRIMARY INSURANCE

Insurance Company:

Plan Name:

Member / Policy ID:

Group Number:

Policy Holder Name:

Policy Holder DOB:

Relationship to Patient: Self Spouse Child Other

Effective Date:

Termination / End Date:

Plan Type: HMO PPO EPO HDHP Other

Claims Address:

Payer ID (Electronic):

BENEFIT DETAILS

Benefit	In-Network	Out-of-Network
Individual Deductible	\$	\$
Deductible Met (YTD)	\$	\$

Benefit	In-Network	Out-of-Network
Family Deductible	\$	\$
Individual Out-of-Pocket Max	\$	\$
OOP Max Met (YTD)	\$	\$
Copay — Primary Care	\$	\$
Copay — Specialist	\$	\$
Coinsurance	___%	___%
Referral Required?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prior Auth Required (this CPT)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Telehealth Covered?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mental Health Parity (if applicable)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> N/A

Network Status of Provider:

In-Network Out-of-Network Not Verified

Benefit Period:

Calendar Year Plan Year Resets: [MM/DD]

SECONDARY INSURANCE (IF APPLICABLE)

Insurance Company:

[Payer Name or N/A]

Member / Policy ID:

[ID Number]

Group Number:

[Group Number]

Policy Holder:

[Name]

Effective Date:

[MM/DD/YYYY]

COB Order:

Primary Secondary Tertiary

Deductible:

\$

Deductible Met:

\$

Copay / Coinsurance:

\$ / ___%

Prior Auth Required?

Yes No

AUTHORIZATION & REFERRAL NOTES

Prior Auth Required for this Visit?

Yes No Not Confirmed

Auth Number (if obtained):

[Auth Number]

Auth Valid Dates:

[MM/DD/YYYY] through [MM/DD/YYYY]

Authorized Visits / Units:

[#]

Referral Required?

Yes No

Referral Number:

[Referral Number or N/A]

**Additional Notes /
Payer Instructions:**

[Any special billing requirements, coordination notes, or flags]

OFFICE USE ONLY — Form completed: Yes Filed to patient chart: Yes Eligibility confirmed in system: Yes

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