BENEFITS VERIFICATION WORKSHEET

Procedure-specific benefit detail for cost estimates and prior auth

Patient & Payer

Patient Name	
Date of Birth	
Patient ID / MRN	
Payer Name	
Plan Name / Product	
Member ID	
Group #	

Service Being Verified

Planned Service Description	
CPT / HCPCS Code(s)	
Diagnosis (ICD-10)	
Planned Date of Service	
Facility / Place of Service	
Rendering Provider NPI	

In-Network Benefits

Deductible (annual)	
Deductible Met YTD	
Copay for this service	
Coinsurance %	
Out-of-Pocket Max	
Out-of-Pocket Met YTD	

Out-of-Network Benefits

OON Deductible	
OON Deductible Met YTD	
OON Coinsurance %	

OON Out-of-Pocket Max	
Balance Billing Allowed? (Y/N)	

Authorization / Predetermination

☐ Prior authorization required for planned CPT

☐ Predetermination available for planned CPT

☐ Medical necessity criteria requested from payer

Auth / Predet Reference #	
Effective / Expiration Dates	
Approved Units or Visits	

Estimated Patient Responsibility

Billed / Allowed Amount	
Payer Estimated Payment	
Estimated Patient Portion	
Estimate Communicated to Patient (Y/N)	

Verification Source

Source (Portal / Phone / EDI 271)	
Rep Name (if phone)	
Payer Reference / Call ID #	
Verification Date / Time	
Verified By (Staff Initials)	

Notes