Insurance and Verification

Patient Name:	DOB:	SS#:
Guarantor Name: (Primary Card Holder)	DOB:	SS#:

Primary Insurance:	Secondary Insurance:
Address:	Address:
Member Phone # (on back of card)	Member Phone # (on back of card)
ID Number :	ID Number :
Group Number:	Group Number:

Insurance Company Verification (To be filled out by office staff)

Scan insurance card and patient's license:		Yes	
Plan Active: Y/N		Showing as Secondary Y/N	
Effective Date:		Effective Date:	
Benefits:		**Benefits:**	
Co-pay/ Co-Ins:		Co-pay/ Co-Ins:	
Deductible:	Met:	Deductible:	Met:
Family Deduct:	Met:	Family Deduct:	Met:
Out of pocket max:	Met:	Out of pocket max:	Met:
Family OOP max:	Met:	Family OOP max:	Met:
HSA (Health savings account)		Met:	
FSA (Flexible spending account)		Met:	
Auth Required: Y/N		Auth Required: Y/N	
Auth #:		Auth #:	
Dates Valid:		Dates Valid:	
# of visits:		# of visits:	
Calendar or plan year		Calendar or plan year	
Start:	to/End:	Start:	to/End:
Visit Limit:		Visit Limit:	
Combined:		Combined:	
Spoke to:		Spoke to:	
Reference # for call :		Reference # for call :	
Date Verified :		Date Verified :	
Time:		Time:	