HEALTH INSURANCE VERIFICATION FORM

Patient Information:

Patient Name: _____
Gender: ☐ Male ☐ Female ☐ Prefer to self-describe: _____
Date of Birth: _____
Address: _____
Social Security Number: _____
Phone: _____ Email: _____

Patient Insurance Information:

Insurance Provider: _____ Policy Number: _____ Group Number: _____
Insurance Provider Phone Number: _____
Subscriber Name: _____ Date of Birth: _____
Subscriber Phone: _____
Subscriber's Relationship to Patient: _____

Insurance Verification:

Is the insurance coverage active? ☐ Yes ☐ No

Begin Date: _____ End Date: _____

Type of Insurance Plan: ☐ HMO ☐ PPO ☐ Medicaid ☐ Medicare ☐ Other: _____

Pre-Authorization Requirements: ☐ Required for some services ☐ Not required

Services requiring Pre-Authorization: _____

Deductibles and Copayments:

Deductible Amount: $_____
Copayment for Specialist Visit: $_____
Deductible Met to Date: $_____
Annual Out-of-Pocket Maximum: $_____
Exclusions and Limitations: _____

Referral Requirements for Specialist Visits: ☐ Required ☐ Not Required

Coverage for Network and Out-of-Network Services:

In-Network: ☐ Covered ☐ Not Covered
Out-of-Network: ☐ Covered ☐ Not Covered

Contact Information for Further Inquiries:

Contact Person Name: _____
Phone: _____ Email :_____

Additional Notes:

_____
_____
_____

Date Verified: _____ Verified by: _____