Insurance Verification Worksheet

PATIENT INFORMATION

Patient name ______________________________ Account# ____________________

Patient's SSN ______________________________ Patient's birthdate ____________________

Patient's PCP ______________________________ PCP's phone ____________________

PRIMARY INSURANCE

Code ________

Company name ______________________________ Contact name ____________________

Address ______________________________ Phone # ____________________

______________________________ Fax # ____________________

Policyholder name ______________________________ Relation to insured ____________________

Policyholders' employer ______________________________

Policy ____________________ Group # ____________ Policyholder SSN ____________________

Effective date ___/___/___

Pre-existing clause? ___NO ___Yes(explain)______________________________

Annual deductible amount $ __________ Deductible met/not met for 20___

Psych coverage? ____NO ____Yes Annual limits? ________________ Covered DX? ________________

Limitations of coverage ______________________________

Copay amount$ ________ Precertification required:

- ○ None
- ○ Each visit
- ○ Each incident
- ○ Other (see notes)

Verified by ___________ on ___ / ___ / ___

Notes: ______________________________

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SECONDARY INSURANCE

Code ________

Company name ______________________________ Contact name ____________________

Address ______________________________ Phone # ____________________

______________________________ Fax # ____________________

Policyholder name ______________________________ Relation to insured ____________________

Policyholders' employer ______________________________

Policy ____________________ Group # ____________ Policyholder SSN ____________________

Effective date ___/___/___

Pre-existing clause? ___NO ___Yes(explain)______________________________

Annual deductible amount $ _____________ Deductible met/not met for 20___

Psych coverage? ____NO ____Yes Annual limits? ________________ Covered DX? ________________

Limitations of coverage ______________________________

Copay amount$ ________ Precertification required:

- ○ None
- ○ Each visit
- ○ Each incident
- ○ Other (see notes)

Verified by ___________ on ___ / ___ / ___

Notes: ______________________________

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C.O.B. ____Yes ____No COMPLETED BY ________________________ Date ________________