



## INSURANCE VERIFICATION FORM

**TO THE PATIENT: THE FOLLOWING INFORMATION IS REQUIRED IN ORDER FOR THE OFFICE TO FILE YOUR INSURANCE. FAILURE TO PROVIDE COMPLETE INFORMATION MAY RESULT IN YOU BEING REQUIRED TO PAY FOR YOUR VISIT IN FULL AT THE TIME OF SERVICE.**

PATIENT NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

### **PRIMARY POLICY HOLDER INFORMATION:**

NAME: \_\_\_\_\_ D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_ S.S. # \_\_\_\_ - \_\_\_\_ - \_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

EMPLOYED BY: \_\_\_\_\_

NAME OF PRIMARY INSURANCE CARRIER: \_\_\_\_\_ INSURANCE COMPANY MAILING ADDRESS: \_\_\_\_\_

GROUP NO: \_\_\_\_\_

I.D. NUMBER: \_\_\_\_\_

EFFECTIVE DATE: \_\_\_\_\_ PHONE: \_\_\_\_\_

**(EFFECTIVE DATES MUST GIVEN)**

### **SECONDARY POLICY HOLDER INFORMATION:**

NAME: \_\_\_\_\_ D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_ S.S. # \_\_\_\_ - \_\_\_\_ - \_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

EMPLOYED BY: \_\_\_\_\_

NAME OF SECONDARY INSURANCE CARRIER: \_\_\_\_\_ INSURANCE COMPANY MAILING ADDRESS: \_\_\_\_\_

GROUP NO: \_\_\_\_\_

I.D. NUMBER: \_\_\_\_\_

EFFECTIVE DATE: \_\_\_\_\_ PHONE: \_\_\_\_\_

**(EFFECTIVE DATES MUST BE GIVEN)**

ARE YOU COVERED BY MEDICARE? \_\_\_\_\_ MEDICARE #: \_\_\_\_\_ RAILROAD? \_\_\_\_\_

ARE YOU COVERED BY MEDICAID? \_\_\_\_\_

**PLEASE GIVE SECRETARY A CURRENT  
MEDICAL ELIGIBILITY FORM FOR MEDICAID.**

**A 1.5% LATE FEE IS DUE & PAYABLE ON ALL PATIENT DUE BALANCES GREATER THEN 30 DAYS PAST DUE.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**PHYSICIAN'S OFFICE USE ONLY BELOW THIS LINE**

CONTACT PERSON: \_\_\_\_\_

PHONE EXT.: \_\_\_\_\_

EFFECTIVE DATE VERIFIED YES NO

IS THIS PLAN A CAPITATED HMO? YES NO

BILLING ADDRESS SAME AS CARD? YES NO

BENEFITS: COPAY: \_\_\_\_\_

DEDUCTIBLE: \_\_\_\_\_ CAP FFS

X-RAY: YES / NO US/ECHO: YES / NO

OFFICE LABS: YES / NO WHICH REF LAB? \_\_\_\_\_

IN OFFICE SURGERY: YES / NO THERAPY: YES / NO

COMPLETE PHYSICAL: YES / NO

WELLNESS: PAP Y / N PSA Y / N MAMMOGRAM Y / N FLEX SIG Y / N

SPECIAL COMMENTS:

\_\_\_\_\_  
\_\_\_\_\_

PRE-EXISTING CONDITION CLAUSE:

\_\_\_\_\_  
\_\_\_\_\_