INSURANCE VERIFICATION

Date of Services ____________________________________

Ordering Physician ____________________________________

Insured: ____________________________________ Patient: ____________________________________

SUBSCRIBER Number: ____________________________________

Group Number: ____________________________________ DOB: ________ / ____________ / ____________
Mo Day Year

Insurance Company: ____________________________________

Billing Address: ____________________________________

____

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Telephone Number: ____________________________________

Benefits: Verified By: ____________________________________ Effective ____________________________________

Deductible ____________________ Met ________________ Ins. Pays ________________ Co-Pay ________________

Pre-Cert Required ❑ Y ❑ N Verified By ____________________________________

Telephone Number: ____________________________ Authorization Number: ____________________

CPT CODES AUTHORIZED

________________________________ Diagnosis: ____________________________________

________________________________ Diagnosis: ____________________________________

________________________________ Diagnosis: ____________________________________

________________________________ Diagnosis: ____________________________________

TYPE OF SERVICE

1. __________________________ Billed Amount: $ __________________________________
2. __________________________ Billed Amount: $ __________________________________
3. __________________________ Billed Amount: $ __________________________________
4. __________________________ Billed Amount: $ __________________________________

PATIENT RESPONSIBILITY (after insurance): $ __________________ In Full

IF PAYMENT AGREEMENT NEEDED: THREE (3) PAYMENTS OF $__________________.