Insurance Verification

Insurance Company_____ Date of Verification: _____ Time: _____

Insurance Phone # _____

Representative Name: _____ Call Reference #:_____

Patient information

Patient's Name:_____ Date of birth:_____

DX Code: _____ ID Number_____ Group #_____

Subscriber Name:_____ Relationship to Patient: _____

Effective date of policy:_____ Termination date (if applicable):_____

Benefits Verification

Provider INN or OON (if OON does U&C apply?)

Office Visit Copay:_____(includes test/ procedure?) Deductible:_____

Coinsurance:_____ Out of Pocket Maximum:_____ Referral required: Yes/No

Pharmacy Benefit Manager: _____ Phone #:_____

Prior Authorization Requirements

PA required for any or the following?

- ☐ MRI (CPT Codes-
- ☐ CT SCAN (CPT Codes-
- ☐ EEG (CPT Codes-
- ☐ NCV (CPT Codes-
- ☐ EMG (CPT Codes-
- ☐ Lumbar Puncture (CPT Codes-
- ☐ PET SCAN (CPT Codes-
- ☐ Sleep Study (CPT Codes-
- ☐ Angiography (CPT Codes-
- ☐ Other (CPT codes-

Prior Auth phone #_____

Notes: