**Insurance Verification Form** your logo here

NOTE: Depending on where and how you practice, you may need to adapt some of these questions. This is only provided as a guideline and is not an approved or recommended verification form.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Rep Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff name completing form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insured Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance Data**

Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Deductible: \_\_\_\_\_\_\_\_\_\_

Amount Met: \_\_\_\_\_\_\_\_\_\_ OOP Max: \_\_\_\_\_\_\_\_\_\_\_\_ OOP Met: \_\_\_\_\_\_\_\_\_\_\_\_

Copay Amount: \_\_\_\_\_\_\_\_\_    Co‐Insurance Amount: \_\_\_\_\_\_\_\_\_\_\_\_

Does patient have a Health Savings Account or Health Reimbursement (FSA) account?    Yes No

Does insurance company pay out of HRA account or do we collect from patient?   Insurance    Patient

Is policy based on a calendar year or contract year?

Calendar Contract If contract year, what are the dates: \_\_\_\_\_\_\_\_\_\_\_\_ Number of visits per year: \_\_\_\_\_\_\_\_\_\_\_\_ Dollar amount per year: \_\_\_\_\_\_\_\_\_\_\_\_

Required pre authorization for care?        Yes    No         Diagnostics?     Yes       No

Is this plan self‐funded? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a double copay for visits with exams or re‐exams? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance Data**

Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Deductible: \_\_\_\_\_\_\_\_\_\_

Amount Met: \_\_\_\_\_\_\_\_\_\_ OOP Max: \_\_\_\_\_\_\_\_\_\_\_\_ OOP Met: \_\_\_\_\_\_\_\_\_\_\_\_

Copay Amount: \_\_\_\_\_\_\_\_\_    Co‐Insurance Amount: \_\_\_\_\_\_\_\_\_\_\_\_

Does patient have a Health Savings Account or Health Reimbursement (FSA) account?    Yes No

Does insurance company pay out of HRA account or do we collect from patient?   Insurance    Patient

Is policy based on a calendar year or contract year?

Calendar Contract If contract year, what are the dates: \_\_\_\_\_\_\_\_\_\_\_\_ Number of visits per year: \_\_\_\_\_\_\_\_\_\_\_\_ Dollar amount per year: \_\_\_\_\_\_\_\_\_\_\_\_

Required pre authorization for care?        Yes    No         Diagnostics?     Yes       No