

Insurance Pre-Verification and Authorization Form

Patient Name: _____ Date of Birth: ____/____/____
First MI Last

Insured Name: _____ Date of Birth: ____/____/____
First MI Last

Name of Insurance Company: _____

Policy #: _____ Group #: _____

Ins. Co. Phone number: (____) _____ - _____ Extension: _____

Name of Insurance Rep: _____ Date of Contact: ____/____/____

Use this portion of the form to verify coverage.

- Y N 1. Is the above carrier primary? If not, who is? _____
- Y N 2. Is the patient covered for office visits and procedures?
- Y N 3. Is preauthorization required? If yes, how do you get #?

Comments _____

- Y N 4. Is there an annual deductible? If yes, how much? \$ _____
 How much of the 2007 deductible is met to date? \$ _____

- Y N 5. Is there a copayment? If yes, how much are copays for the following?
 E/M visits \$: _____ Surgery \$: _____ Lab \$: _____

- Y N 6. Are there any pre-existing conditions on the policy?
 Identify: _____

Use this portion to obtain authorization

Ins. Co. Phone number (____) _____ - _____ Date of Contact: ____/____/____

Name of Insurance Rep _____ Extension: _____

CPT code Covered	Diagnosis	Charge	Covered	Not
1. _____	_____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
2. _____	_____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
3. _____	_____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
4. _____	_____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
5. _____	_____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>

Authorization Number #: _____