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	*Diagnosis*	*Charge*	*Covered*	*Not Covered*
1._____	_____	$_____	❑	❑
2._____	_____	$_____	❑	❑
3._____	_____	$_____	❑	❑
4._____	_____	$_____	❑	❑
5._____	_____	$_____	❑	❑

Authorization Number #: _____