

INSURANCE COVERAGE VERIFICATION FORM

Patient or Dependent's Name: _____

DOB: _____ / _____ / _____

SSN: _____ - _____ - _____

Employee's Name: _____

DOB: _____ / _____ / _____

SSN: _____ - _____ - _____

Employer's Name: _____

Group#: _____

Insurance Company's Name: _____

Address for Claims: _____

Phone#: () _____

Contact Person's Name: _____

Plan # or Name: _____

Effective Date: _____ / _____ / _____

Usual & Customary Fee:

Yes ___ ***No*** ___ ***Other*** _____

Family Coverage:

Yes ___ ***No*** ___

Individual, Family, or No Deductible:

Indv. ___ ***Faml.*** ___ ***No Deductible*** ___

Maximum Annual Benefit Per Member:

\$ _____

****Plan Covers:***

Preventive -

_____ % ***Prev. Deductible - \$*** _____

Basic -

_____ %

Major -

_____ % ***Basic & Major Ded. - \$*** _____

Other -

_____ %

Special Notes:

Verifier's Initials and Date Verified:

_____ / _____ / _____

Office Use Only