SAMPLE
Insurance Verification Form

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: _____

Any per authorization for advanced imaging: **X-ray** Yes No **MRI** Yes No

ACN form required? Yes No

Is there a limit on modalities when billed with a CMT code? Yes No

Is this plan self-funded or ERISA? _____

Is there a double copay for visits with exams or re-exams? _____