OB-GYNE ASSOCIATES OF LAKE FOREST

PATIENT PROCEDURE VERIFICATION FORM

(*COMPLETE THIS FORM BY CALLING YOUR INSURANCE COMPANY*)

ELIGIBILITY:

PATIENT NAME: _____ DATE OF BIRTH: _____

INSURANCE CARRIER: _____ EFECTIVE DATE: _____

POLICY NAME: _____

POLICY#: _____ GROUP#: _____

PLAN TYPE: □ HMO □ PPO □ POS OTHER: _____

POLICY HOLDER'S NAME: _____ DATE OF BIRTH: _____

BENEFITS FOR: PROCEDURE CODE: _____ DIAGNOSIS CODE: _____

QUESTIONS TO ASK YOUR INSURANCE COMPANY BEFORE THE ABOVE SERVICES ARE PROVIDED TO YOU BY OUR OFFICE:

1. IS DR. _____ IN-NETWORK WITH MY PLAN/POLICY? □ YES □ NO
   IF NO, DO I HAVE OUT-OF NETWORK BENEFITS? □ YES □ NO
   IF YES, WHAT ARE THE OUT-OF-NETWORK BENEFITS?
   DEDUCTIBLE: $_____ CO-INSURANCE: $ _____ OUT-OF-POCKET: $_____

2. IS THIS DIAGNOSIS CODE COVERED UNDER MY POLICY? (DIAGNOSIS CODE: _____)
   □ YES □NO
   IF NO, WILL I BE RESPONSIBLE FOR THE BALANCE? □ YES □ NO

3. IS THIS PROCEDURE COVERED UNDER MY POLICY? (CPT CODE: _____)
   □ YES □ NO
   IF NO, WILL I BE RESPONSIBLE FOR THE BALANCE? □ YES □ NO
   IF YES, WHAT IS THE PROCESS THAT IS NEEDED TO BE DONE IN-ORDER TO HAVE IT COVERED? _____
   _____

4. DOES THIS PROCEDURE NEED A PRE-AUTHORIZATION? □ YES □ NO
   IF YES, HOW DO I GET IT PRE-AUTHORIZED? _____
   _____

7. IS THERE ANYTHING ELSE I MAY NEED TO KNOW OR DO TO HAVE THIS MEDICATION COVERED? _____
   _____

PATIENT SIGNATURE: _____ DATE: _____