INSURANCE VERIFICATION

Today's Date: _____ APPT. DATE: _____TIME:_____ Visit for: _____

P't Name: _____ Tel: _____

D.O.B.: _____/ _____/ _____ SS#: _____

INSURANCE NAME: _____ **ID:** _____

Effect Date: _____/ _____/ _____GROUP #: _____ INS. TEL#: _____

Policy Holder: **Name** _____ **SS#:** _____ **D.O.B.:**____/____/____

ACTUAL VERIFICATION: **SPOKE W/:** _____

Sono, UDS, NST

COPAY: $ _____, **PE**: $_____, **OV**: $_____, **Infertility**: $ _____, **Dx Test**: $ _____, **OB Care**: $_____

Type of Insurance/ Coverage: HMO PPO EPO MCD MCR Other_____

DEDUCTIBLE: $_____ **Apply to**: PE OV Infertility procedure OB Sono Lab InP't OutP't MET: $_____

UDS Bx

COINSURANCE: ins _____%/ self_____% up to: $_____then Cover _____%

PE: ins _____%/ self_____% up to: $_____then Cover _____%

OV: ins _____%/ self_____% up to: $_____then Cover _____%

OB: ins _____%/ self_____% up to: $_____then Cover _____%

Procedure: ins _____%/ self_____% up to: $_____then Cover _____%

Sono: ins _____%/ self_____% up to: $_____then Cover _____%

InP't/ OutP't: ins _____%/ self_____% up to: $_____then Cover _____%

◆**EMC NDC**: Y N **PAYER ID #**:_____

CLAIM ADDRESS: _____

◆**COVER:** ◆**REFERRALS NEEDED**:

WELL WOMEN / PE: Y N_____Y N

INFERTILITY: Y N / Basic OV Dx Test Office/Hosp Procedure _____Y N

Other PROBLEM: Y N_____Y N

Office PROCEDURE: Y N_____Y N

Hosp PROCEDURE: Y N_____Y N

OB CARE: Y N_____Y N

INCIDENTAL PROBLEM DURING OB CARE: Y N ?pay separately? _____Y N

NST/ OB Sono: Y N_____Y N

WHO GET REFERRALS FOR:SONO, PROCEDURE, FU: PCP_____ SPECIALIST:_____

◆**LAB**: _____ ◆**TOB AUTH#:** _____

◆**PCP NAME**: Dr._____ **PCP PROVIDER ID#:** _____ **NPI#:** _____

TEL #: _____ FAX #: _____ **MCR#:** _____

PCP Address: ____