INSURANCE VERIFICATION FORM

MUST BE FILLED OUT ENTIRELY FOR EVERY INSURANCE PATIENT

DATE: _____ PERSON VERIFYING: _____

NAME (IF OTHER THAN PATIENT): _____ DOB: _____

PATIENT NAME: _____ DOB: _____

PRIMARY INSURANCE: _____

ID #: _____ GROUP #: _____

SECONDARY INSURANCE: _____

ID #: _____ GROUP #: _____

PAYER ID #: _____ NAME REPRESENTATIVE: _____

PHONE #: _____

IS THE PATIENT'S COVERAGE ACTIVE (YES OR NO): _____

EFFECTIVE DATE OF POLICY: _____

OUT OF NETWORK BENEFITS:

AMOUNT BENEFIT: _____ PER (EAR/S) _____
EVERY _____ (MONTH/YEAR) (BENEFIT WINDOW)

MAX ALLOWED DOLLAR AMOUNT FOR THE BENEFIT: $_____

CO-INSURANCE PERCENTAGE: _____DEDUCTIBLE APPLY TO BENEFIT?____

DEDUCTIBLE AMOUNTS:

OUT OF NETWORK	**INDIVIDUAL DEDUCTIBLE**	**FAMILY DEDUCTIBLE**	**OOP INDIVIDUAL**	**OOP FAMILY**
AMOUNT OF DEDUCTIBLE				
AMOUNT MET				
AMOUNT REMAINING				

IS THE BENEFIT ONLY FOR CHILDREN? _____

USUAL OR CUSTOMARY PRICE GUIDELINE/MAXIMUM? _____

HAS THE BENEFIT BEEN USED WITHIN THE BENEFIT WINDOW? _____

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WWW.EARRF.ORG

INSURANCE VERIFICATION FORM

DOES THE PATIENT NEED PRIOR AUTHORIZATION? _____

FAX/PHONE # TO OBTAIN PRIOR AUTH: _____

CAN WE BALANCE BILL THE PATIENT? _____

IS A PHYSICIAN REFERRAL OR MEDICAL CLEARANCE NEDDED? _____

DOES THE CLAIM NEED TO BE SUBMITTED TO MEDICARE PRIOR FOR REIMBURSEMENT? _____

IN NETWORK BENEFIT – *FOR MATCHING OR UTILIZING 3RD PARTY ONLY*

AMOUNT BENEFIT: _____ PER (EAR/S) _____
EVERY _____ (MONTH/YEAR) (BENEFIT WINDOW)

MAX ALLOWED DOLLAR AMOUNT FOR THE BENEFIT: $_____

CO-INSURANCE PERCENTAGE: _____DEDUCTIBLE APPLY TO BENEFIT?____

DEDUCTIBLE AMOUNTS:

OUT OF NETWORK	INDIVIDUAL DEDUCTIBLE	FAMILY DEDUCTIBLE	OOP INDIVIDUAL	OOP FAMILY
AMOUNT OF DEDUCTIBLE				
AMOUNT MET				
AMOUNT REMAINING				

IS THE BENEFIT ONLY FOR CHILDREN? _____

USUAL OR CUSTOMARY PRICE GUIDELINE/MAXIMUM? _____

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