[Please Add Practice Name & Address]

VERIFICATION FORM – HEALTH INSURANCE

Patient: _____

EIN: _____ Provider's License (if needed or applicable): _____ Other: _____

Policy Holder (i.e., the name on the card)	Insurance Carrier / Plan Administrator	Carrier's / Administrator's Phone Number
ID Number (Box 1A of CMS 1500)	Group Number (or enter "NONE")	

1. **Is [Your Specialty] covered?** ☐ YES ☐ NO **2. Is the policy currently in effect?** ☐ YES ☐ NO

   Maximum Dollar Amounts? ☐ N/A ☐ per year $____ ☐ per visit $___ (☐ Pay ☐ Allow) ☐ Per Diagnosis: $_____

   How much met? $_____

   Maximum # of Visits? ☐ N/A ☐ per year _____ ☐ per incident: _____ How many met? _____

   Are these limits contained in the POLICY itself, or are they INTERNAL operational limitations? ☐ Policy ☐ Internal

   If you wish to document benefits discrimination by this plan, complete a separate form, "Verification of Benefits Discrimination."

3. **Is the Patient currently covered under the policy?** ☐ YES ☐ NO
4. **What was the effective date of coverage for the Patient?** Effective Date of Coverage for the Patient: ___/___/___
5. **Is there a pre-existing conditions clause?** ☐ YES ☐ NO **If yes, indicate its terms:**

   How far back in time will the carrier look for a pre-existing condition? _____ ☐ Months ☐ Years

   If a pre-existing condition is found, how far forward in time will the carrier not pay? _____ ☐ Months ☐ Years

   If the patient can show continuous coverage up until the patient's effective date, does the carrier waive the pre-existing clause?
6. **Do you accept or honor assignment?** ☐ YES ☐ NO
7. **(If this is a personal injury case) Is coverage expressly secondary to either Medpay or PIP?**

   ☐ Not secondary to either ☐ secondary to Medpay ☐ secondary to PIP
8. **Is a referral or authorization needed?** ☐ NO ☐ YES, otherwise no coverage at all ☐ YES, for in-network benefits

   Referral or Auth #: _____ # of visits authorized: _____ From ___/___/___ To __/___/___
9. **Benefits** The following benefits are ☐ In-network ☐ Out-of-network Is the provider in-network? ☐ YES ☐ NO

   Flat Copay: $_____ ☐ First Visit ☐ Per Visit

   Deductible: $_____ How much of PATIENT'S deductible has been met? $ ____ Patient's % after deductible: ____%

   Deductible is ☐ Calendar Year ☐ Other Year from: ___/___ to: ___/___ ☐ Per Diagnosis
10. **Is the Plan governed under ERISA?** ☐ YES ☐ NO
11. **Name/Address for Claims**_____
12. **Name/Address for Appeals**_____ Fax Number: _____
13. **Name/Address for SPDs** _____ Fax Number: _____

    If you don't have a Summary Plan Description on file send a request to the Plan Fiduciary or to the Plan Administrator, or request a current copy from the EBSA Public Disclosure Room (202-693-8673)
14. **Are there any other material limitations that apply?** ☐ YES ☐ NO Explain: _____

    _____

    _____

Your Initials: _____ Date called: ___/___/___ Spoke with: _____ ID# of Representative: _____