Verification of Insurance Benefits

Today's Date: _____ Date of Surgery: _____

Patient name: _____ Insured name & DOB: _____

Patient relationship to insured: Primary: Self Spouse Child Other

Insurance Company: _____

Insured's Employer: _____ Effective date: _____

Policy Number: _____ Group number: _____

Phone number of insurance called to verify benefits: _____

Name of person at insurance company who verified benefits: _____

Verification Information: Primary

Date of verification: _____ Second opinion required? YES NO

Precertification or referral required? _____ Phone number called to get precert? _____

Name of person who gave pre-cert number: _____ Pre Cert # _____

In network benefits: Deductible:$ _____ /Met:$ _____ Coinsurance: % _____

Out of Pocket: $ _____ / Met:$ _____

Verification Information: Secondary

Date of verification: _____ Second opinion required? YES NO

Insurance Company: _____

Policy Number: _____ Group number: _____

Precertification or referral required? _____ Phone number called to get pre-cert? _____

Name of person who gave pre-cert number: _____ Pre Cert # _____

In network benefits: Deductible:$ _____ /Met:$ _____ Coinsurance: % _____

Out of Pocket: $ _____ / Met:$ _____