



INSURANCE BENEFITS VERIFICATION FORM

Patient Information

Full Legal Name:

Date of Birth:

Insurance Company:

Primary Insured Name:

Insured Date of Birth:

Subscriber ID/Member ID:

Group ID (if applicable):

Benefits Information

Reference Number:

Date and Time of Call:

Representative Name:

Effective Date:

Coinsurance or Copay?

Deductible? How much met? Applies?

Out of Pocket Maximum? How much met? Applies?

Limitations?

of Visits? # of Visits Used?

In Combination with?

Any Restrictions?

Need Authorization or Referral?