Insurance Verification Form

Patient, plan, eligibility, and general benefits

PATIENT AND APPOINTMENT

PATIENT NAME

DATE OF BIRTH

DATE OF SERVICE

RENDERING PROVIDER

FACILITY / LOCATION

VISIT OR SERVICE BEING VERIFIED

CPT / HCPCS (IF KNOWN)

APPOINTMENT TIME

SUBSCRIBER AND COVERAGE

PAYER / PLAN NAME

MEMBER ID

GROUP NUMBER

SUBSCRIBER NAME

SUBSCRIBER DOB

RELATIONSHIP

PLAN TYPE

☐ HMO ☐ PPO ☐ EPO ☐ POS ☐ Medicare ☐ Medicaid ☐ Other

ELIGIBILITY AND PLAN STATUS

ELIGIBILITY STATUS

☐ Active ☐ Inactive ☐ Unable to verify

EFFECTIVE DATE

TERMINATION DATE

NETWORK STATUS

☐ In network ☐ Out of network ☐ Unclear

SERVICE COVERED

☐ Yes ☐ No ☐ Unclear

GENERAL BENEFITS

PRIMARY CARE COPAY

SPECIALIST COPAY

URGENT CARE COPAY

INDIVIDUAL DEDUCTIBLE - TOTAL

INDIVIDUAL DEDUCTIBLE - MET

INDIVIDUAL DEDUCTIBLE - REMAINING

FAMILY DEDUCTIBLE - TOTAL

FAMILY DEDUCTIBLE - MET

FAMILY DEDUCTIBLE - REMAINING

PATIENT COINSURANCE %

PLAN PAYS %

BENEFIT PERIOD / RESETS

INDIVIDUAL OOP MAX

INDIVIDUAL OOP MET

INDIVIDUAL OOP REMAINING

FAMILY OOP MAX

FAMILY OOP MET

FAMILY OOP REMAINING

Eligibility and benefits information is not a guarantee of coverage or payment. Confirm current payer rules and the specific service before relying on this form.
Completed forms may contain PHI. Store, transmit, retain, and dispose of them only through your practice-approved workflow.
Document the payer source, reference number, unresolved exception, owner, and next action.

Insurance Verification Form

Service review, payer trail, follow-up, and sign-off

SERVICE-SPECIFIC COVERAGE

SERVICE / PROCEDURE

BENEFIT CATEGORY

COVERED FOR THIS SERVICE

☐ Yes ☐ No ☐ Unclear

VISIT / FREQUENCY / UNIT LIMIT

USED / REMAINING

COVERAGE LIMITS, EXCLUSIONS, CARVE-OUTS, OR CLINICAL POLICY NOTES

PRIOR AUTHORIZATION AND REFERRAL

PRIOR AUTHORIZATION REQUIRED

☐ Yes ☐ No ☐ Unclear

REFERRAL REQUIRED

☐ Yes ☐ No ☐ Unclear

AUTH VENDOR / PORTAL / PHONE

AUTHORIZATION NUMBER / STATUS

AUTHORIZATION VALID DATES

AUTHORIZED UNITS / VISITS

REFERRAL NUMBER / VISITS

PAYER CONTACT AND VERIFICATION TRAIL

VERIFICATION METHOD

☐ 270/271 ☐ Portal ☐ Phone ☐ Other

DATE / TIME

PAYER REPRESENTATIVE

PHONE / PORTAL

REFERENCE / TRACE NUMBER

ESTIMATED PATIENT RESPONSIBILITY

COPAY

DEDUCTIBLE

COINSURANCE

NON-COVERED / OTHER

ESTIMATED TOTAL

Estimate only. Final patient responsibility depends on claim adjudication, allowed amount, accumulators, coverage, and payer processing.

FOLLOW-UP AND EXCEPTIONS

☐ No exception ☐ Demographic mismatch ☐ Inactive coverage ☐ COB issue

☐ Auth pending ☐ Policy review ☐ Patient contact ☐ Other

OWNER

DUE DATE

RESOLUTION / NEXT ACTION

VERIFICATION SIGN-OFF

VERIFIED BY

DATE / TIME

NOTES / DOCUMENTATION LOCATION

Eligibility and benefits information is not a guarantee of coverage or payment. Confirm current payer rules and the specific service before relying on this form.
Completed forms may contain PHI. Store, transmit, retain, and dispose of them only through your practice-approved workflow.
Document the payer source, reference number, unresolved exception, owner, and next action.