INSURANCE CONFIRMATION / VERIFICATION

New Developed Nations   Rickey "Deekon" Jones

Today's Date:_________________________ Appointment Date:__________________________

Patient Name:_________________________ Ins. Company:______________________________

Patient Phone #:________________________Ins. Phone #:_______________________________

Patient Birthdate :_______________________Subscriber Name:___________________________

Mailing Address: _______________________Subscriber ID: __________________________

_____________________________________Claim/Group #:_____________________________

Okay to leave voice mail?   Y   N   Call w/Benefits?   Y   N

Date Verified: ________________________ Contact Person: _____________________________

Pre-Auth Required? ____________________Ref # for call: ______________________________

Deductible: ________________Met for this year: ________________

Co-Pay : Yes _$____________ No   Effective date: ____________________________________

Calendar Year $/Visit Limit : ____

Visits Remaining _____________________

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COMMENTS:

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Mail claims to:

Fax to: 509-323-1607