ELIGIBILITY INSURANCE VERIFICATION FORM

PATIENT NAME: _____ DOB: _____ ID#_____SS#_____
SUBSCRIBER NAME: _____ DOB: _____ ID#_____ SS#_____
INSURANCE COMPANY: _____ GROUP#_____ PH#_____
EMPLOYER/GROUP PLAN NAME:_____
ADDRESS: _____
NETWORK? ▢ IN ▢ OUT FEE SCHEDULE? _____ PAYOR ID#_____
EFFECTIVE DATE: _____ BENEFIT PERIOD: ▢ CALENDAR YR ▢ BENEFIT PERIOD _____

ANNUAL MAXIMUM: $_____ REMAINING: $_____

INDIVIDUAL DEDUCTIBLE: $_____ REMAINING $_____

COMPLETED BY: _____ DATE: _____
METHOD: ▢ ONLINE ▢ FAX ▢ PHONE: REF#_____

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