# INSURANCE VERIFICATION

Patients Name: ___________________________________________ DOB:________________________

Insured Name:_______________________________________________ Insured Date of Birth: ___________________________

Relationship to Patient: ___ Mother ____Father ____Stepparent Other:___________________________

## INSURANCE

Insurance Name: _______________________________ ID#:____________________________________ GP:_______________

Insurance Phone#: ______________________________ Timely Filing Limit: ______________________________

Effective Date: ________________ HRA OR HSA Pre-Cert Required? _______ LifeMax: $_________________________

Ind Ded: $_____________ Ind Ded met: $_____________ Fam Ded: $_____________ Fam Ded met: $_____________

Ind OOP: $_____________ Ind OOP met: $_____________ Fam OOP: $_____________ Fam OOP met: $_____________

Co-Ins: ___________ Co-Pay:______________ Calendar year (Jan1-Dec31) OR Plan Year: ____________________

## COVERAGE

| | Covered Co-Pay | Covered Ded | Comments: |
|---|---|---|---|
| Sick OV | ☐ | ☐ | ____________________________________________ |
| Physical | ☐ | ☐ | ____________________________________________ |
| Laboratory | ☐ | ☐ | ____________________________________________ |
| Other Procedures<br>i.e. Injections/Skin Tag removal/EKG etc. | ☐ | ☐ | ____________________________________________ |

Spoke with: ___________________________________ Reference number:__________________________________

Date:_____________________ Time: ___________ Employees Initials: ___________________

______ **I understand the information provided to me is a quote and an estimated coverage. This verification in no way guarantees covered services or benefits explained to me. Any statement made by our staff regarding your coverage in no way or guarantees that your care here will be covered by your insurance company, and you will be held responsible for your account. It is the patient's responsibility to determine if our clinic & provider is in network with the patient's insurance as well as any insurance coverage and benefits.**

I authorize the release of any information pertinent to my case to my insurance carrier mentioned above. By signing this form, I am indicating that I have been explained and understand of my medical coverage and I have read and understood the financial policy.

Print Name: ___________________________________________ DOB: __________________________________________

Signature: ____________________________________________ Date: __________________________________________

All Medical Billing & Consultants, LLC