INSURANCE VERIFICATION

Patients Name: ____ DOB:__________________________

Insurance Name: ____________________________________ ID#:_____________________________________ GP:______________

Company Phone Number: ______________________________ Insured Name:______________________________________

Relationship to Patient: ______ Mother _____Father _____Stepparent _____Other:_____________________

Social Security number__________________________ Insured Date of Birth: __________________________

PRIMARY OR SECONDARY

Effective Date: _______/ ________/ ____________ Terms Date: ____________________________

Individual Deductible: $__________________ Individual Deductible met: $____________

Out of Pocket: $________________________ Out of Pocket met: $________________________

Is Deductible included in OOP: YES NO

Is Co Ins/Pay included in OOP: YES NO

Coinsurance: ________ / ____________ Co- Pay: $ ____________

Lifetime Max: $___________________________ Claim Submission Time frame: ____________________________________

Circle ONE: Calendar year or Plan year:______________________________

	Covered		Co-Pay		Comments:
	YES	NO	YES	NO	
Sick Child Care	☐	☐	☐	☐	____
Well Child Care	☐	☐	☐	☐	____
Laboratory	☐	☐	☐	☐	____
Hearing Screening	☐	☐	☐	☐	____
Immunizations	☐	☐	☐	☐	____
Vision Screening	☐	☐	☐	☐	____

Spoke with: _______________________________________ Reference number:______________________________________

Date:_______/ _______/ ____________ Time: ________________ Employees Initials: ______________

By signing this form I am indicating that I have been explained and understand of my medical coverage and I agree to my insurance terms and limitations. If at any given time my insurance is terminated and/or my insurance does not pay for service rendered I understand that I will have to pay out of my pocket for anything that is not covered by the insurance unless the service is covered under a contractual agreement between my provider and my insurance carrier.

What was given to us is only a quote of benefits it is not a guarantee of payment unless otherwise required by law. All benefits are subject to the terms, conditions, limitations, and exclusions under the member's policy, including the patient's effective status on the actual date of service.

Parents Printed Name: ____ Date: _______/ ________/ ____________

Parents Signature: ____ Witness Initials: ___________

ALL MEDICAL BILLING & CONSULTANTS