Benefit Verification Form

Fill Out This Section:

Patient Information							
Date:		Patient Name:		DOB:		Phone:	
Surgery Date:		From:				Fax:	

Provider & Diagnosis Code Information					
State:		Physician/ Facility:			
Place of Service:		Phone:		Fax:	
Physician Contact:		Primary Diagnosis:			
Procedure:		Secondary Diagnosis:			
		Tertiary Diagnosis:			

Primary Payer					
Primary Payer:					
Payer Type:		ID#		Group#	
Effective Date:		Phone:		Fax:	
Insurance Contact:					

Secondary Payer					
Secondary Payer:					
Payer Type:		ID#		Group#	
Effective Date:		Phone:		Fax:	
Insurance Contact:					

Collect Health Plan Information From Payer:

Physician Services				Facility Services			
TIN:				TIN:			
NPI:				NPI:			
In-Network?:				In-Network?:			
Coverage Percentage:				Coverage Percentage:			
Individual Deductible:	$	Met:	$	Individual Deductible:	$	Met:	$
Out of Pocket Maximum:	$	Met:	$	Out of Pocket Maximum:	$	Met:	$
Co-Payment:	$			Co-Payment	$		
Authorization#				Authorization#			

Additional Comments:	

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