

Medical Insurance Verification



Yidam Energy Healing
Conquer From Within

PATIENT INFORMATION

Patient Name _____

Patient Address _____

City _____ ST _____ Zip _____

Home Phone No _____ Work Phone No _____

Social Security No _____ Date of Birth _____

M _____ F _____

Diagnosis: _____

Applicable ICD-9-CM Diagnosis code(s) _____

Anticipated CPT Code(s) for Procedure(s): _____

PATIENT INSURANCE INFORMATION

Primary Insurance Co _____ Policy No _____ Group No _____

Primary Insurance Phone No _____

Subscriber's Name _____ Date of Birth _____

Subscriber's Relationship to Patient _____

Secondary Insurance Co _____ Policy No _____ Group No _____

Secondary Insurance Phone No _____

Subscriber's Name _____ Date of Birth _____

Subscriber's Relationship to Patient _____

PATIENT ELIGIBILITY AND BENEFITS INFORMATION

Effective Date of Coverage: _____

Coverage Terminated? Yes No Date: _____

Plan Type: HMO PPO POS Other: _____

In-Network Benefits: \$ _____

Co-Payment

\$ _____ Deductible Has Deductible Been Met? Yes No

\$ _____ Co-insurance \$ _____ Other Out-of-Pocket Expense

Benefits for Treatment? Yes No

Is a Referral Necessary? Yes No

Is Prior-Authorization Required? Yes No

Out-of-Network Benefits? Yes No

Out-of-Network Financial Responsibilities? Yes No

INSURER INFORMATION

Call Date: _____ Time of Call: _____

Name of Insurance Rep _____ Phone No / Ext _____

Prior-Authorization Phone No _____ Fax No _____

Prior-Authorization Contact Name _____

Prior-Authorization Approval No _____

Referral Phone No _____ Fax No _____

Referral Contact Name _____

Notes: _____
