INSURANCE VERIFICATION

Date of Call: **Patient Name:** **DOB:**

Phone Number Dialed:

List any direct line or prompts:

Insurance Company:

Rep Name:

Member ID:

Plan Type:

Effective Date:

In Network:

Plan pays at:

Deductible: $

Deductible Met: $

The remainder on Deductible: $

Maximum Out of Pocket:

Max OoP Met: $

The remainder on Max OoP: $

Patient Co-Pay / Co-Insurance %:

Referral Required:

Prior Authorization Required:

HCPCS Code(s):

How item to be Billed: (R) Rental OR (P)Purchase

Is there a "cap" on HCPCS:

History of the Item:

CALL REF #:

**************** REMEMBER, once verified-update "Insurance Verification" in Bright Tree under Insurance Tab ****************