



**INSURANCE VERIFICATION**

Date of Services \_\_\_\_\_

Ordering Physician \_\_\_\_\_

Insured: \_\_\_\_\_ Patient: \_\_\_\_\_

SUBSCRIBER Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Mo Day Year

Insurance Company: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Benefits: Verified By: \_\_\_\_\_ Effective \_\_\_\_\_

Deductible \_\_\_\_\_ Met \_\_\_\_\_ Ins. Pays \_\_\_\_\_ Co-Pay \_\_\_\_\_

Pre-Cert Required  Y  N Verified By \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Authorization Number: \_\_\_\_\_

**CPT CODES AUTHORIZED**

- \_\_\_\_\_ Diagnosis: \_\_\_\_\_
- \_\_\_\_\_ Diagnosis: \_\_\_\_\_
- \_\_\_\_\_ Diagnosis: \_\_\_\_\_
- \_\_\_\_\_ Diagnosis: \_\_\_\_\_

**TYPE OF SERVICE**

1. \_\_\_\_\_ Billed Amount: \$ \_\_\_\_\_
2. \_\_\_\_\_ Billed Amount: \$ \_\_\_\_\_
3. \_\_\_\_\_ Billed Amount: \$ \_\_\_\_\_
4. \_\_\_\_\_ Billed Amount: \$ \_\_\_\_\_

**PATIENT RESPONSIBILITY** (after insurance): \$ \_\_\_\_\_ In Full

**IF PAYMENT AGREEMENT NEEDED:** THREE (3) PAYMENTS OF \$ \_\_\_\_\_.