Health Insurance Verification Form

Appt:

Name:_____

DOB:_____

Insurance:_____ Group

Ins. Phone #:_____

Co-Pay:_____

Co-Ins:_____

Deductible:_____ Met? Yes/No

Out of Pocket:_____

Eligibility Effective date: _____

Covered Benefits:

EKG (93000):_____

INJECTIONS (96372):_____

TELEVISIT:_____

Rep: _____

Ref #: _____