INSURANCE ELIGIBILITY VERIFICATION CHECKLIST

1. PATIENT & APPOINTMENT DETAILS

Patient Name: _____ **Date of Birth:** _____ **Appointment Date/Time:** _____

Subscriber Name: _____ **Relationship to Patient:** _____ **Provider:** _____

2. INSURANCE & VERIFICATION INFORMATION

Insurance Company: _____ **Member ID:** _____ **Group #:** _____

Plan Type: ☐ HMO ☐ PPO ☐ EPO ☐ POS ☐ Medicare ☐ Medicaid ☐ Other

Policy Effective Date: _____ **Effective Through / Term Date:** _____ **Verification Date:** _____

Verified By: _____ **Call Reference #:** _____

Verification Method: ☐ Portal ☐ Phone ☐ Fax
☐ Policy Active Confirmed ☐ In-Network Status Confirmed ☐ Covered Service Confirmed

3. PATIENT RESPONSIBILITY (BENEFITS)

Specialist Copay:	PCP Copay:	Coinsurance:	Deductible:	Deductible Met:	Out-of-Pocket Max:
$ _____	$ _____	% _____	$ _____	$ _____	$ _____

4. AUTHORIZATION & COVERAGE LIMITATIONS

Referral Required? ☐ Yes ☐ No **If yes, Referral #:** _____

Prior Auth Required? ☐ Yes ☐ No **If yes, Auth #:** _____

Coverage Limitations / Exclusions: _____

5. NOTES / PAYER COMMENTS

_____

_____

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