MEDICAL INSURANCE VERIFICATION FORM

PATIENT INFORMATION

Full Name: _____

Date of Birth: _____ Gender: _____

Address: _____

Phone Number: _____

INSURANCE INFORMATION

Insurance Company: _____

Policy Number: _____

Group Number: _____

Policy Holder Name: _____

Relationship to Patient: _____

PROVIDER INFORMATION

Provider Name: _____

Provider Address: _____

Provider Phone Number: _____

INSURANCE VERIFICATION DETAILS

Verified Coverage? _____

Effective Date: _____

Expiration Date: _____

Covered Services: _____

Co-payment Amount: _____

Deductible Amount: _____

Authorization Required? _____

Notes:

LEGAL ACKNOWLEDGMENT

The undersigned hereby certifies that the information provided above is accurate and complete to the best of their knowledge. This verification form is subject to all applicable federal and state laws governing medical insurance coverage and privacy, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA). Unauthorized use or disclosure of this information is prohibited by law. The verification of insurance coverage does not guarantee payment. Final determination of benefits is subject to the

terms and conditions of the insurance policy. This form shall be considered a legally binding document between the parties named herein under the laws of the United States.

Patient or Authorized Representative Signature	**Insurance Company Representative Signature**
Signature: _____	Signature: _____