

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: _____

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