Bloom & Be

Therapy and Educational Services

Insurance Verification Form

Patient Information

Patient Name

Patient Address

City ST Zip

Home Phone No Work Phone No

Social Security No Date of Birth

M F

Diagnosis:

Applicable ICD-9-CM Diagnosis code(s)

Anticipated CPT Code(s) for Procedure(s):

Patient Eligibility and Benefits Information

Effective Date of Coverage:

Coverage Terminated? Yes No Date:

Plan Type: HMO PPO POS Other:

In-Network Benefits: $

Co-Payment $ ______
Has Deductible Been Met? Deductible Yes No Co-insurance $ ________

Other Out-of-Pocket Expense Benefits for Treatment?

Yes No

Is a Referral Necessary? Yes No

Is Prior-Authorization Required? Yes No

Out-of-Network Benefits? Yes No
Out-of-Network Financial Responsibilities? Yes No

Patient Insurance Information

Primary Insurance Co Policy No Group No

Primary Insurance Phone No

Subscriber's Name Date of Birth

Subscriber's Relationship to Patient

Secondary Insurance Co Policy No Group No

Secondary Insurance Phone No

Subscriber's Name Date of Birth

Subscriber's Relationship to Patient

Insurer Information

Call Date: Time of Call:

Name of Insurance Rep Phone No / Ext

Prior-Authorization Phone No Fax No

Prior-Authorization Contact Name

Prior-Authorization Approval No

Referral Phone No Fax No

Referral Contact Name

Notes: