Dr. John Doe Medical Practice, LLC

TAX ID: _____ **Group NPI: _____** **Individual NPI: _____**
For Practice Location: _____ ***Assigned Provider*** _____

MEDICAL BENEFITS & ELIGIBILITY VERIFICATION

Related to MVA or W/C?: YES / NO **Date of Accident (for MVA/WC):** ___/___/____
Date Today: _____ New Patient Appointment Date:_____
Patient's Name: _____ D.O.B. __/__/__
Address: _____ Phone: _____
PCP's / Referring Provider's Name and Phone Number: _____
Primary Insurance:_____ Insurance Phone: _____
Insurance ID No. _____ Group No. _____ Insurance Plan (e.g. PPO/HMO/):_____
Policy Holder's Name: _____ Policy Holder's SS# _____ Policy Holder's DOB: _____
Insurance Claims Address: _____
Secondary Insurance:_____ Insurance Phone: _____
Insurance ID No. _____Group No. _____ Insurance Plan:_____
Policy Holder's Name: _____ Policy Holder's SS# _____ Policy Holder's D.O.B. __/__/__

Copay: $_____ Does the patient need a referral? _____
Office Procedures (POS 11): Require Precert? _____
ASC Procedures (POS 24): Require Precert? _____
Precert Phone# _____ Precert Fax# _____
Deductible: $_____ Amount Met: $_____ Coinsurance: __ % Out ofPocket: $_____ Amount Met: $_____
DOES THE PATIENT HAVE AN OUT OF NETWORK BENEFITS? _____
Deductible: $_____ Amount Met: $_____ Coinsurance: __ % Out ofPocket: $_____ Amount Met: $_____

DIAGNOSTIC TESTING

Is EMG and NCS? Y N Pre-cert required? Y N
Is Drug Screening covered (done in the Office)? Y N Pre-cert required? Y N

PT / OT / SLP Services

Is PT/OT/SLP a Covered Benefit? Y N Pre-cert required? Y N
How Many Visits Allowed? _____ *per condition* _____ *per calendar year* _____ *per life time* _____ other.
Number Used - _____ Dollar Amount _____ Days

For WORKERS COMP/MVA CLAIMS: Please Check: ____ MVA ____ Workers Comp
CLAIM NUMBER: _____ **POLICY NUMBER:** _____
Insurance Company: _____ Insurance Phone: _____
Adjustor's Name: _____Phone: _____ FAX: _____
Case Nurse Manager's Name: _____ Phone: _____ FAX: _____
Precert Number Phone Number: _____Precert Fax Number: _____
Body Part (related to MVA/WC Claim): _____
Claim's Address: _____
Attorney's Office (if available): _____ Phone: _____ FAX: _____
Provider Relations Rep's Name: _____
Phone call Reference # _____ Date: _____