
INSURANCE VERIFICATION FORM

Please complete this insurance verification form prior to your visit with the doctor.

Use this form as a questionnaire when calling the member services number on your insurance card.

It is your responsibility to call your insurance company and/or your primary physician for referral authorization. Thereafter you are responsible to inform the office staff of referral updates, extensions and/or change of insurances.

Insurance Company: _____ Effective Date of Policy: _____

Insurance phone # for verification: _____

Is there a Specialist Office Visit Co-Pay? YES / NO If YES, Amount? Percentage? _____

Does your policy require a referral to see a Specialist? YES / NO _____

Do you have to go to certain labs, hospitals, pharmacies? If yes please list the names of the required facilities:

Hospital: _____

Labs: _____

Pharmacy: _____

** Please note if your insurance allows you to go anywhere, indicate so in the space provided*

If we are seeing you for infertility related services, does your policy cover infertility services? YES
NO _____

If YES, does your policy require precertification or a pre-determination letter for these services? YES NO _____

I understand that this form must be completed accurately, which may require that I call my insurance company **PRIOR** to my first visit, and that it is part of my medical record.

Patient Signature _____ Date _____