INSURANCE ELIGIBILITY AND BENEFITS VERIFICATION

PATIENT/SUBSCRIBER INFORMATION:

NAME: _____ DATE OF BIRTH: _____/_____/_____

CONTACT NUMBER: _____

DRIVER LICENSE ID: _____ Exp. Date: _____

INSURANCE NAME: _____

MEDICAL GROUP NUMBER: _____ SUBCRIBER ID NUMBER: _____

ALPHA PREFIX: _____

PLAN/PRODUCT: _____

CURRENT EFFECTIVE DATE: _____

CONFIRMATION NUMBER: _____

DIAGNOSTIC ULTRASOUND:

PROCEDURE CODE: _____ ULTRASOUND / TYPE: _____

COVERAGE: YES / NO PERCENTAGE (%): _____

COPAY: YES / NO : $ _____

DEDUCTABLE: YES / NO : $ _____

SELF PAY: YES / NO : $ _____

COMMENTS: _____

_____

_____

VERIFIED BY: _____ DATE: _____