Insurance Verification Form

Patient information	
Name:	Date of birth:
Address:	
Phone number:	Email address:
Insurance policy number:	Group number:
Emergency contact name:	Emergency contact number:
Insurance provider information	
Insurance company name:	
Policyholder name (if different from patient):	
Insurance provider phone number:	
Effective date of coverage:	
Expiration date of coverage (if applicable):	
Type of coverage (HMO, PPO, etc.):	
Insurance coverage information	
Covered services (check all that apply):	
☐ General medical ☐ Mental health ☐ Physical therapy ☐ Dental ☐ Vision ☐ Other (specify):	
Pre-authorization required? ◯ Yes ◯ No	
Deductible amount:	Met? ◯ Yes ◯ No
Copayment amount:	
Coinsurance amount:	
Out of pocket limit:	
Patient's signature: By signing below, I authorize the healthcare provider to verify my insurance coverage as outlined in this form.	
Signature:	Date: