Princeton Neurological Surgery

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PATIENT INSURANCE VERIFICATION FORM

Patient Information

Name: _____ Date of birth: ____/____/____
Last First Middle *Month Day Year*

Address: _____
Street City State Zip Code

Phone Number: (home) _____ (Cell) _____ (Work) _____

Gender: _____ Male _____ Female Social Security Number: _____

Employer name: _____

Employer address: _____
Street City State Zip Code

Insurance Information

Primary Carrier *Plan Name*	*Secondary Carrier* *Plan Name*
Policy Number *Group Number*	*Policy Number* *Group Number*
Effective Date *Carrier Phone Number*	*Effective Date* *Carrier Phone Number*
Subscriber's Name *Date of Birth*	*Subscriber's Name* *Date of Birth*
Relationship to Patient	*Relationship to Patient*

Patient Name _____ Date of Birth _____

Patient Eligibility Information (For Office Use Only)

Date of insurance call: _____/_____/_____ Time of insurance call: _____ ☐ am ☐ pm
Month Day Year

Name of insurance contact(s): _____ Call reference number(s): _____

Out-of-Network

Member: $_____ $_____ $_____ $_____
Co-payment *Deductible* *Co-Insurance* *Out of Pocket Maximum*

Family: $_____ $_____ $_____ $_____
Co-payment *Deductible* *Co-Insurance* *Out of Pocket Maximum*

How much of the deductible has been met? $_____

Is deductible applied to out of pocket max? ☐ Yes ☐ No

Is a referral necessary? ☐ Yes ☐ No ☐ Self-funded plan ☐ fully funded plan

Out of Network database used to determine OON reimbursement specific to the terms of the member/patient's plan policy:

Fair Health ☐ HIAA ☐ Wasserman ☐ Medicare _____ 100% _____ 200% _____ 300%

Other, if so, describe in detail _____ Payor ID: _____

Claim mailing address: _____

Supporting document submission address: _____

_____
PNS Billing Representative Name *Date*

Patient Name (printed): _____ *Date:* _____/_____/_____
Month Day Year

Patient Signature: _____