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: _____