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: