Insurance Verification Form

Date:_____ **Time**:_____ a.m p.m **Person Calling**: _____

Insurance:_____ **Telephone #**:_____

Rep Name and Reference Number: _____

Patent First Name:_____ **Last Name**:_____

Member ID:_____ **Date Of Birth:**_____

Effective Date:_____

Deductible: Yes / No

Deductible: Individual $_____ Met:$_____ / Family $_____ Met:$_____

Copayment: $_____ **Coinsurance**: Yes / No – If yes $_____

Out of Pocket Maximum:

Individual OOP? Yes $_____ Met $_____ Remaining $_____

Family OOP? Yes $_____ Met $_____ Remaining $_____

Is Telemedicine covered? Yes / No If yes, **Authorization required**? Yes / No

Is there a limit of Telemedicine visits? Yes / No **Is the GT modifier recognized**? Yes / No

Would an evaluation and management codes be covered with a GT modifier or 95 modifier?

Are the following Codes covered: (Indicate which codes are covered by circle)

90785 / 90791 / 90792 / 90832 / 90833 / 90834 / 90835 / 90836 / 90837 / 90846 / 90847 /

99441 / 99442 / 99443 / 98966 / 98967 / 98968 / 99212 / 99213 / 99214 / 99215

Additional Notes:_____

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