PATIENT INSURANCE VERIFICATION

NAME:____DOB:___________________

INS. CO.:____________________________________ PHONE: __________________

SUBSCRIBER/INSURED NAME:____

INS. ID#:________________________________ GROUP:_______________________

INS. CO. CONTACT NAME:____

IN NETWORK:_____________ OUT OF NETWORK:_______________

EFF DATE OF INS:______________ PRE-EXISTING CONDITION WAITING PERIOD: **YES** [ ] **NO** [ ]

DEDUCTIBLE: **YES** [ ] **NO** [ ] AMOUNT:

COPAY:_________________ COINSURANCE _____________________

REFERRAL REQUIRED? **YES** [ ] **NO** [ ] AUTHORIZATION NEEDED FOR PODIATRY? **YES** [ ] **NO** [ ]

ANY EXCLUSIONS FOR PODIATRY? **YES** [ ] **NO** [ ] ____________________________________

CAP ON PODIATRY TREATMENT? **YES** [ ] **NO** [ ] AMOUNT: ______________________

ARE THE FOLLOWING SERVICES COVERED? | **OUT OF NETWORK COSTS**

X-RAYS : **YES** [ ] **NO** [ ]

ORTHOTICS: **YES** [ ] **NO** [ ]

________________________________ ___________________________

ROUTINE NAIL CARE: **YES** [ ] **NO** [ ] ___________________________

DIAGNOSTIC ULTRASOUND (76880) **YES** [ ] **NO** [ ] ___________________________

GUIDED ULTRASOUND INJECTION (761424) **YES** [ ] **NO** [ ] ___________________________

PHYSICAL THERAPY: **YES** [ ] **NO** [ ] ___________________________

OF VISITS ______ CO-PAY? __________ ___________________________

OF MODALITIES _________ ___________________________

PRECERT REQ? **YES** [ ] **NO** [ ] ___________________________

VERIFIED BY: ____________________________ DATE: _____________________