

Insurance Verification

Worksheet

Tax ID _____

NPI _____ Billing

NPI _____ Facility

NPI _____ Provider



AUDIBEL

Clinic: _____ Zip: _____ Completed By: _____ Date: _____

Scan & upload to eDocs once completed Scan & upload copy of insurance cards to eDocs

Patient Information (PSC/PCC completes)

Patient Name: _____ Cycle ID: _____ DOB: _____

Policy Holder: _____ DOB: _____

Insurance Company: _____ Member ID: _____ Group ID: _____

Policy Effective From-Thru: _____ Type of Policy: PPO / POS / HMO / EPO / Other: _____

Primary Insurance: Yes No Other Insurance: Yes No Medicare Primary: Yes No

Is this Medicaid? Yes No

Verification (Questions to ask insurance company)

Must talk to a LIVE person to verify hearing aid benefits. DO NOT rely on "recorded" response.

Representative's Name: _____ Verification Phone#: _____

Call Reference #: _____ Website Verification: Yes No (If YES, include printout in upload to eDocs.)

Hearing Aid Benefit? Yes No NPI used to verify benefits: _____

Is there an age limitation for coverage? Yes No If Yes, Age: _____

Is the patient's plan through a Third Party? Yes No If Yes, Third Party Payer/Benefit & Copay: _____

*LETTERS COINCIDE WITH INSURANCE CALCULATOR	In Network		Out of Network	
	SELF	FAMILY	SELF	FAMILY
C Subject to Deductible? <input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$	\$	\$
D Deductible Paid To-Date?	\$	\$	\$	\$
Out-of-Pocket Max?	\$	\$	\$	\$
Out-of-Pocket Paid To-Date?	\$	\$	\$	\$
A Allowed Amount? (per aid) <i>*Use V5257 if ref code is required</i>	\$ <i>*Ask for actual number. If no number supplied, default to \$1500/aid for all payers except UHC default to \$2500/aid</i>		Usual & Customary Charges	
E Co-Insurance %? (Patient Portion)				
F Maximum Benefit? <input type="checkbox"/> Yes <input type="checkbox"/> No	\$		\$	
OR				
Q Fixed Coverage Amount?	\$			
How often does this coverage renew? _____ Has it been used? <input type="checkbox"/> Yes <input type="checkbox"/> No Amount Available: \$ _____				
Is an Rx or Referral required? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, PCP Phone #: _____ PCP Fax #: _____ <small>*Some UHC plans require a "Written Recommendation from a Physician".</small>				
Is an authorization required? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Phone #: _____ Authorization #: _____ <small>*If code is required for authorization, use H90.3. This can always be updated to another diagnosis if needed. Use V5261 at \$3000 if requiring a HCPCS code.</small>				
Is the patient required to see an Audiologist? <input type="checkbox"/> Yes <input type="checkbox"/> No				

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Comments