# Insurance Verification Form

Date: _____ Time: _____ am pm

Insurance: _____ Telephone: _____

Rep Name and Reference Number: _____

Patient First Name: _____ Last Name: _____

Member ID: _____ DOB: _____

Plan is: _____

Effective Date: _____

Plan pays: _____% After deductible of: _____

Deductible? Yes $_____ Met $_____

Family Ded? Yes $_____ Met $_____

**Out of Pocket Maximum**

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

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

Is Telemedicine Covered? Yes No If yes, requires authorization? Yes No
*(Specifically code 99444)*

Is the GT Modifier Recognized? Yes No Is there a limit of telemedicine visits? Yes No

Would an evaluation and management code be covered with a GT Modifier? Yes No

Timely Filing OON _____ Elec Payer ID # _____

Additional Notes: _____