

MAJOR MEDICAL VERIFICATION

Patient's Name: _____

Patient's SS# _____ Patient's DOB: _____

Insured's Name: _____
Address: _____

Insured's Employer: _____

Insured's Social Security No: _____ Insured's DOB: _____

OFFICE USE ONLY

Insurance Company Name _____

Address to send bills to: _____

Ins. Co. Phone # _____

Group #: _____ Policy #: _____

Person spoken with at insurance company _____

Effective Date: _____ Deductible: _____

Are there out-of network benefits? _____ Amt. Deductible Met _____

Percentage Paid: _____ Maximum Payout: _____

Co-payment: _____

Modalities: _____ X-Rays _____

Number of visits covered: _____

Completed by _____ Date _____

Spoke with patient on _____ Employee's Initials _____

Entered in computer on _____ By _____