

ABP Insurance Verification Form

Provider : _____

FAX TO: 619-334-3158

Patient Name: _____ Patient DOB: _____ Insured ID#: _____

Patient Address: _____ City _____ State _____ Zip _____

Insured's Name: _____ Group# _____ Ins. Co Phone#: _____

Ins. Co. Name: _____

Ins. Co. Claims Address: _____

GENERAL INFORMATION

Date: _____

Person Spoke To: _____

Effective Date: _____

Plan Type: _____

CALENDAR (Jan-Dec) / ANNUAL Plan
If annual plan, from _____ to _____

IN / OUT of Network Benefits

DEDUCTIBLE INFORMATION

Individual Deduct \$ _____ Amt Met \$ _____

Family Deduct \$ _____ Amt Met \$ _____

Deduct Combined In & Out of Network YES / NO

PROCEDURES COVERED INFORMATION

Exams Covered? YES / NO % Paid _____

Initial Exams Only? YES / NO

97112 Neuromuscular Reeducation YES / NO

97140 Manual Therapy YES / NO

97010 Hot/Cold Packs YES / NO

97026 E stimulation YES / NO

97124 Massage Therapy YES / NO

NOTES: _____

VISIT LIMIT INFORMATION

Visit Maximum _____ Visits Remaining _____

Combined With _____

Combined In & Out of Network? YES / NO

When meeting deduct, are max # visits used? YES / NO

Annual \$ Max _____ Amt used \$ _____

PLAN PAYMENT INFORMATION

% Paid _____ OR Visit \$ Max _____

National Account? YES / NO

If YES, payment may go to patient.

OUT OF POCKET INFORMATION

Max out of pocket \$ _____ Amount met \$ _____

Once met claims pay at 100% YES / NO

REFERRAL INFORMATION

Need a Dr.'s referral? YES / NO

Rx needed? YES / NO

Auth Required? YES / NO PH# _____

Additional Visits PH# _____

Submit clinical treatment form after _____ visit

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SAMPLE VERSION ONLY