WellsBrooke
CERTIFIED HOME HEALTH CARE

Insurance Verification Form

Patient Name:		MR#:	Date:
SSN#:	DOB:	Age:	Sex:
DX:			
Policy Holder's Name as Printed on Card:			DOB:
Relationship to Patient:		MSP Form Completed per Protocol: ☐ Yes ☐ No	
Contract #:	Group #:	Effective Date: ☐ Part A ☐ Part B	
Insurance Company Name and Mailing Address:			
Contact Name:	Phone #:	Fax #:	
Employer Name and Mailing Address:		Phone #:	
Services Covered: ☐ RN ☐ Hha ☐ PT ☐ PTA ☐ OT ☐ SLP ☐ MSW ☐ Med. Supplies ☐ LABS			
Maximum Service :_____ Days_____ Visits per _____		Maximum Coverage: $_____	
Deductible: ☐ Yes ☐ No Amount $ _____ Deductible Met? ☐ Yes ☐ No If yes, date met: _____			
Co-Insurance: ☐ Yes ☐ No	Co-Pay: ☐ Yes ☐No Co-Pay Amount $_____		
Out of Pocket Expense: ☐ Yes ☐ No Expense Met? ☐ Yes ☐ No Out of Pocket Amount $:_____			
Other Information/Benefits:			
Will Representative Fax/Email Authorization: ☐ Yes ☐ No	Requires Certified Agency: ☐ Yes ☐ No		
Items to be furnished/sent with billing (✓ all that apply): ☐ Plan of Treatment ☐Medical Orders ☐ Treatment Notes ☐ Others (specify):_____			
Pre-cert Required: ☐ Yes ☐ No Billing Rate/Negotiation: _____ Approved By:_____ (Authorized Signature)			
Special Instructions/Information:			
Filing Limits:	Sequential Billing: ☐ Yes ☐ No		
Billing Address and Phone # (if different from above):			
Information Collected By (Signature): **Date:**			

Time/Date:			
Addt'l Auth. Approved: (type/amount of visits)	Thru:	Thru:	Thru:
Contact Name:			
Collected By Initials:			
Auth/Reference #:			