**A blue and white logo

AI-generated content may be incorrect.**

Date of Inquiry:

**INSURANCE VERIFICATION FORM**

Patient Name: Policy Holder: 

Patient DOB: DOB of Policy Holder: 

Provider/NPI: Billing NPI:

Primary Insurance: Secondary Insurance: 

Primary Plan ID: Secondary Plan ID:

Primary Group #: Secondary Group #:

Phone Number: Phone Number:

Preauthorization required: Yes No Preauthorization required: Yes No

Authorization #: Authorization #:  
Medical clearance required: Yes No Obtained: Yes No

**COVERAGE DETAILS**

Deductible: Unmet deductible: Deductible: Unmet deductible:

Copay: Co-insurance: Copay: Co-insurance:

Out-of-pocket maximum: Out-of-pocket maximum:

TPA benefits: Yes No TPA benefits: Yes No

Notes:

Hearing aid benefits:

aid(s) per months/years aid(s) per months/years

Maximum benefit: Maximum benefit:

Upgrade option beyond benefit: Upgrade option beyond benefit:

Notes:

Insurance representative name: Insurance representative name:

Reference number: Reference number: