AMPLIFY YOUR VALUE
POWERED BY THE AMERICAN ACADEMY OF AUDIOLOGY

INSURANCE VERIFICATION FORM

Date of Inquiry:

Patient Name:
Patient DOB:
Provider/NPI:
Primary Insurance:
Primary Plan ID:
Primary Group #:
Phone Number:
Preauthorization required: Yes ☐ No ☐
Authorization #:
Medical clearance required: Yes ☐ No ☐

Policy Holder:
DOB of Policy Holder:
Billing NPI:
Secondary Insurance:
Secondary Plan ID:
Secondary Group #:
Phone Number:
Preauthorization required: Yes ☐ No ☐
Authorization #:
Obtained: Yes ☐ No ☐

COVERAGE DETAILS

Deductible: Unmet deductible:
Copay: Co-insurance:
Out-of-pocket maximum:
TPA benefits: Yes ☐ No ☐

Notes:

Hearing aid benefits:
aid(s) per months/years
Maximum benefit:
Upgrade option beyond benefit:

Notes:

Insurance representative name:
Reference number:

Deductible: Unmet deductible:
Copay: Co-insurance:
Out-of-pocket maximum:
TPA benefits: Yes ☐ No ☐

Notes:

Hearing aid benefits:
aid(s) per months/years
Maximum benefit:
Upgrade option beyond benefit:

Notes:

Insurance representative name:
Reference number:

Please note that verification of benefits is not a guarantee of payment. Patients are encouraged to contact member services to confirm benefits. For internal use only.