

Podiatry Billing Services
INSURANCE VERIFICATION FORM

Tax ID # _____
Group / Individual NPI # _____

Date information taken: _____ Date of Appointment: _____ Time: _____

Patient Name: _____ Pt's DOB: ____/____/____

Patient's Complaint: _____

Patient's: Home Phone: () _____ Cell/Work: () _____

Primary Insurance: _____ Phone #: () _____

Claims Address: _____

Policy Holder's Name: _____ Policy Holder's DOB: ____/____/____

Policy #: _____ Group #: _____

Effective Date: ____/____/____ Is this policy active: Yes___ No___

Any Podiatry Exclusions: _____

Is the provider participating with insurance? Yes___ No___ If No, Out-of-Network benefits: Yes___ No___

Are referral(s) /Authorization(s) required? Yes___ No___ (If Yes, please attach form)

Type of Service:	Co-pay	Deductibles /Co-insurance	Amount Satisfied
Office Visits (New or Est)	_____	_____	_____
X-Rays	_____	_____	_____
Office Surgery (nail/lesions)	_____	_____	_____
Out PT SX (bunion/hammertoe)	_____	_____	_____

Is there separate coverage for DME? Co-pay \$_____ Deductible \$_____ Met \$_____

Is precertification required for DME? Yes___ No___

Are the following covered: Custom Orthotics (L3000) covered for Diabetics ONLY? Yes___ No___

Custom Orthotics (L3000) covered for Plantar Fasciitis (728.71)? Yes___ No___

Diabetic Shoes (A5500) and inserts (A5512/A5513) covered (other than Medicare)? Yes___ No___

DME: Night Splints___ Walking Cast___ Arizona Brace___ Ankle Brace___ Diagnosis:_____

Nail Debridement (11721) covered for Diabetics ONLY? Yes___ No___

Laboratory Used _____ Diagnostic testing facility (MRI) _____

Date Verified: _____ Verified By: _____

Spoke With: _____ Confirmation #: _____