Benefit Verification Form

Appointment Date		Provider	Dr.	Completed By:	
Account #	**«ANumber»**	Reason for the visit	Allergy Benefits		
Patient Name:	**«PName»**	Date of Birth:	**«PDOB»**		
Guarantor Name:	«GName»	Subscriber:	«PL1SubName»		
Primary Insurance:	**«PL1CarrName»**				
Policy Effective Date:		Insurance Phone #		Spoke with:	
Policy #:	«PL1Cert»	Suffix #	«PL1CertSuffix»	Group #	**«PL1GroupNo»**
Ref needed?	**Yes** / **No**	Pre-Exist	**Yes** /**No**	Copay	**$**
Is the copay per visit or Doctor's office visit?	**Visit / Office Visit**				
Patient's Deductible is	**$**	Amount Met as of today	**$**		
Patient's Out of Pocket	**$**	Amount Met as of today	**$**		
Patient's Co-Insurance Percent	**%**	Insurance Percent	**%**		
HRA or HSA: **Yes / No**	Total Amount: **$**	Amount Remaining: **$**			