Eligibility Inquiry Form

Date: _____ Representative Name: _____

Patient's Name: _____ Date of Birth: _____

Insurance Company: _____ Phone: _____

Service Date: _____ Codes (CPT, ICD)_____

Policy Effective Date: _____

Check the box if applicable.

□ Policy requires precertification?	Phone # _____
□ Policy requires referrals?	Referral Number _____
□ Capitated laboratory?	Lab name: _____
□ Capitated radiology?	Facility Name: _____
□ Copay required?	Amount: _____
□ Deductible required?	Amount, has it been met?_____
□ Co-insurance required?	Amount: _____
□ Primary care physician?	Name: _____

Miscellaneous Notes:

_____
_____
_____
_____
_____
_____

Precertification Request

Date: _____ Insurance Company: _____
Phone: _____ Representative Name: _____

Rendering Doctor: _____ Facility Name: _____

Patient's Name: _____ Date of Birth: _____

Patient's Insured ID: _____

Service Date: _____ Codes (CPT, ICD)_____

Clinical Indications: _____

□ Notes / Documentation Sent
□ Via Fax #_____
□ Via Mail _____
□ Via Email _____

Approval date: _____ Precertification number _____

Miscellaneous Notes:
_____
_____
_____
_____
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_____