

OB-GYNE ASSOCIATES OF LAKE FOREST

IUD VERIFICATION FORM

Account # _____

Patient Name: _____

Date of Birth: _____

Insurance Carrier: _____

Effective Date: _____

Group#: _____

Member#: _____

****PLEASE COMPLETE THIS FORM BY CALLING YOUR INSURANCE COMPANY & RETURNING IT TO THE OFFICE****

**** COMPLETED FORMS CAN BE FAXED TO OFFICE AT 847-234-8155****

PROCEDURE (CPT) CODES

DIAGNOSIS (ICD-10) CODES

58300 IUD INSERTION

58301 IUD REMOVAL

Z30.430 IUD INSERTION

Z30.432 IUD REMOVAL

IUD CODES

J7298 MIRENA (5YRS)

J7300 PARAGARD (10YRS)

J7301 SKYLA (3YRS)

J7296 KYLEENA (5YRS)

J7297 LILETTA (3YRS) A4550 - SURGICAL TRAY (USED FOR ALL IUDS)

1. Is the doctor In-Network with my Policy? Yes No

Dr. Hubbell

Dr. Holden

Dr. Huang

Dr. Heiberger

Dr. Oh

Dr. Tart

2. If the doctor is Out-Of-Network, do I have Out-Of- Network Benefits? Yes No

3. Are the above codes covered by my insurance Policy? Yes No

4. If the codes are denied by my insurance, I **Will** be responsible for the balance (*please initial*) _____

5. Will the IUD code be covered under my: Medical Benefits or Pharmacy Benefits?

6. If covered under Pharmacy Benefits, what is the Specialty Pharmacies contact information?

Name: _____ Phone# _____

Address: _____

7. Will a Pre-Authorization be required? Yes No

Phone number to obtain a Pre-Authorization: _____

Ask for a Call Reference # from Insurance Rep. _____

Patient Signature: _____ Date: _____

****PLEASE ALLOW 2 WEEKS FOR REVIEW & TO RECEIVE A CALL FROM A NURSE TO SCHEDULE YOUR APPOINTMENT****

****IF YOU NEED TO RESCHEDULE OR CANCEL YOUR PROCEDURE, YOU MUST DO SO WITHIN 48 HOURS OF YOUR SCHEDULED APPOINTMENT TO AVOID BEING CHARGED****