

OB-GYNE ASSOCIATES OF LAKE FOREST

PATIENT MEDICATION VERIFICATION FORM

(COMPLETE THIS FORM BY CALLING YOUR INSURANCE COMPANY)

ELIGIBILITY:

PATIENT NAME: _____ DATE OF BIRTH: _____

INSURANCE CARRIER: _____ EFFECTIVE DATE: _____

POLICY NAME: _____

POLICY#: _____ GROUP#: _____

PLAN TYPE: HMO PPO POS OTHER: _____

POLICY HOLDER'S NAME: _____ DATE OF BIRTH: _____

BENEFITS FOR: MEDICATION CODE: _____ DIAGNOSIS CODE: _____

QUESTIONS TO ASK YOUR INSURANCE COMPANY BEFORE THE ABOVE SERVICES ARE PROVIDED TO YOU BY OUR OFFICE:

1. IS DR. _____ IN-NETWORK WITH MY PLAN/POLICY? YES NO

IF NO, DO I HAVE OUT-OF-NETWORK BENEFITS? YES NO

IF YES, WHAT ARE THE OUT-OF-NETWORK BENEFITS?

DEDUCTIBLE: \$ _____ CO-INSURANCE: \$ _____ OUT-OF-POCKET: \$ _____

2. IS THIS DIAGNOSIS CODE COVERED UNDER MY (MEDICAL OR PHARMACY) BENEFITS? _____

(DIAGNOSIS CODE: _____) YES NO

IF NO, WILL I BE RESPONSIBLE FOR THE BALANCE? YES NO

3. IS THIS MEDICATION COVERED UNDER MY (MEDICAL OR PHARMACY) BENEFITS? _____

(CPT CODE: _____) YES NO

IF NO, WILL I BE RESPONSIBLE FOR THE BALANCE? YES NO

IF YES, WHAT IS THE PROCESS THAT IS NEEDED TO BE DONE IN-ORDER TO HAVE IT COVERED? _____

4. DOES THIS MEDICATION HAVE TO BE ORDERED THROUGH MY SPECIALTY PHARMACY? YES NO

IF YES, WHAT IS THE NAME OF MY SPECIALTY PHARMACY? _____

5. DOES THE MEDICATION NEED PRE-AUTHORIZATION? YES NO

IF YES, HOW DO I GET IT PRE-AUTHORIZED? _____

6. IS THERE ANYTHING ELSE I MAY NEED TO KNOW OR DO TO HAVE THIS MEDICATION COVERED? _____

PATIENT SIGNATURE: _____ DATE: _____