ABP Insurance Verification Form

Fax to (650) 458-9209

Patient Name: _____ Patient DOB: _____ Insured ID#: _____

Patient Address: _____ City: _____ State: _____ Zip Code: _____

Insured's Name: _____ Group #: _____ Ins. Co Phone#: _____

Ins Co. Name: _____

Ins. Co. Claims Address: _____

General Information

Date: ____ / ____ / ____

Person Spoke To: _____

Effective Date: _____

Plan Type: _____

Calendar (Jan-Dec) / Annual Plan — If annual plan, from_____ to _____

IN / OUT of Network Benefits

Visit Limit Information

Visit Maximum: _____ Visits Remaining: _____

Combined With: _____

Combined In & Out of Network: _____

When meeting deduct, are max # visits used? YES NO

Annual $ Max _____ Amt used $_____

Deductible Information

Individual Deduct $ _____ Amt Met $ _____

Family Deduct $ _____ Amt Met $ _____

Deduct Combined In & Out of Network: YES NO

Plan Payment Information

% Paid _____ or _____ Visit $ Max _____

National Account? YES NO

If yes, payment may go to patient.

Procedures Covered Information

Exams Covered?	99212	YES	NO	99213	YES	NO
% Paid _____						
Initial Exams Only?	99202	YES	NO	99203	YES	NO
Basic Acp?	97810	YES	NO	97811	YES	NO
Acp w/E Stim	97813	YES	NO	97814	YES	NO

97112	Neuromuscular Reeducation	YES	NO
97140	Manual Therapy	YES	NO
97010	Hot/Cold Packs	YES	NO
97026	E Stimulation	YES	NO
97124	Massage Therapy	YES	NO

Out of Pocket Information

Max Out of Pocket $_____ Amount Met $_____

Once met claims pay at 100% YES NO

Referral Information

Need a Dr's referral? YES NO

RX needed? YES NO PH#_____

Auth Required? YES NO

Additional Visits PH#_____

Submit clinical treatment form after _____ visits.

Notes: