



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:

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