

INSURANCE VALIDATION FORM

Date _____ New Patient _____ Est. Patient Update _____

Primary _____ HMO or PPO Secondary _____ HMO or PPO

VALIDATION INFORMATION

Patient _____ SSI _____ - _____ - _____
Insured _____ Relationship _____
Insured's Employer _____ Employer Phone () _____ - _____
Insurance _____ ID# _____ Group# _____
Claims Address _____
Claims Phone () _____ - _____ Benefits Phone () _____ - _____

IN NETWORK BENEFITS

Co-pay _____ Deductible _____ Deductible Met YES NO
If no, amount Met to Date _____ Insurance Pay % _____ Patient % _____
Out of Pocket Amount _____ Miscellaneous Amount _____

OUT OF NETWORK BENEFITS

Co-pay _____ Deductible _____ Deductible Met YES NO
If no, amount Met to Date _____ Insurance Pay % _____ Patient % _____
Out of Pocket Amount _____ Miscellaneous Amount _____

PROVIDER VALIDATION

EFF Date _____
Primary Care Provider _____ Phone () _____ - _____
EFF Date _____
IPA _____ Phone () _____ - _____

EXAM COVERAGE

PAP SMEAR	YES	NO	WELL WOMAN	YES	NO
COLPOSCOPY	YES	NO	ENDOMETRIAL	YES	NO
CERVICAL DIALATION	YES	NO	PESSARY INSERT	YES	NO
DEPO PROVERA	YES	NO	NORPLANT	YES	NO
DIAPHRAM	YES	NO	INFERTILITY	YES	NO
IUD	YES	NO			
If yes, Supplier	IPS	Pharmacy			
DATING SCAN	YES	NO	LAB WORK	YES	NO
OTHER	YES	NO	OTHER	YES	NO

MATERNITY GROUPINGS

In Network Benefits Deductible Amount _____
Insurance Amount _____ Patient Amount _____

Out of Network Amount _____
Insurance Amount _____ Patient Amount _____

HOSPITAL GROUPINGS

Stay _____ Vaginal Delivery Days _____ C-Section Days _____
Circumcision Coverage YES NO
If yes, is pre authorization required? YES NO
In Network Hospital St. Mary's VVCH DVH Other

MATERNITY LOG

Date _____ Authorized Personnel _____ Verified By _____
DOS _____ Authorized Personnel _____ Verified By _____

Date _____ Authorized Personnel _____ Verified By _____
DOS _____ Authorized Personnel _____ Verified By _____

Date _____ Authorized Personnel _____ Verified By _____
DOS _____ Authorized Personnel _____ Verified By _____

Changes _____

