FOCUS PEDIATRICS
WHERE THE FOCUS IS ON YOU

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Patient Insurance Verification

Complete this **1-page form** in full. Insurance details are not necessary for patients who meet the insurance opt-out requirements noted below. If more than two health plans need to be added, feel free to request another copy of this form.

Patient full legal name

Insurance opt-out: Select "Yes" if the patient is planning on self-pay for healthcare services or has a pending insurance health plan, otherwise select "No". ☐ Yes ☐ No

1. PRIMARY INSURANCE

Add in details for the primary health plan that should be billed first for the patient's care at our practice.

Member full name		Coverage start date	
Member date of birth		Coverage end date	
Member ID		Payer mailing address	
Insurance provider			
Plan name			
Group ID		Purpose of mailing address	

Is the patient the policy holder for this health plan? If yes, ignore the questions below. ☐ Yes ☐ No

Policyholder full name		Relationship to patient	
Policyholder date of birth			

2. SECONDARY INSURANCE

Add in details for the secondary health plan that should be billed after the primary health plan for the patient's care at our practice.

Member full name		Coverage start date	
Member date of birth		Coverage end date	
Member ID		Payer mailing address	
Insurance provider			
Plan name			
Group ID		Purpose of mailing address	

Is the patient the policy holder for this health plan? If yes, ignore the questions below. ☐ Yes ☐ No

Policyholder full name		Relationship to patient	
Policyholder date of birth			