

## INSURANCE VERIFICATION POLICY

**Policy No:**

**Approved by:**

**Effective Date:**

### I. POLICY

To verify that all patients that will be seen at ( \_\_\_\_\_ ) are covered by insurance prior to the delivery of treatment.

### II. SCOPE

This policy applies to all outpatient sites performing chemotherapy and radiation therapy services.

### III. PROCEDURE

Following are detailed procedures to be followed when completing an insurance verification form.

1. The financial specialist is responsible for completing the following sections of the insurance verification form at the time all new patients call for an appointment for medical or radiation oncology. Patient's insurance should be re-verified as required based on region but recommended to be no less than one time per month or when patients notify the office that their insurance coverage has changed. Insurance cards should be requested for verification at every office visit and updated accordingly.
  - **Patient Name**—Complete patient's name in full.
  - **Patient Date of Birth**—Enter the patient's birthday.
  - **Date of Appointment**—Enter the date of the patient's appointment.
  - **Date Appointment Scheduled**—Enter the date that the patient called the office for an appointment.
  - **Scheduled by**—Enter the name of the person who scheduled the appointment.
  - **Date**—Enter the date that you called the insurance company to verify patient's insurance.
  - **Insurance Name (Primary)**—Enter the name of the patient's primary insurance company.
  - **Guarantor**—Enter the name of the individual in whose name the insurance is listed.
  - **Relationship**—Enter the relationship of the patient to the guarantor (self, spouse, child).
  - **Policy #** —Enter the policy number, if applicable, for the primary insurance company.
  - **Group #** —Enter the group number, if applicable, for the primary insurance company.

## FINANCIAL ADVOCACY NETWORK

- **Insurance Name (Secondary)**—Enter the name of the patient’s secondary insurance company name.
  - **Guarantor**—Enter the name of the individual in whose name the insurance is listed.
  - **Relationship**—Enter the relationship of the patient to the guarantor (self, spouse, child).
  - **Policy #** —Enter the policy number, if applicable, for the secondary insurance company.
  - **Group #** —Enter the group number, if applicable, for the secondary insurance company.
2. Once you have completed the insurance verification form with the sections listed above, contact the primary insurance company or use an online system to verify coverage for the patient. Complete the following sections:
- **Phone Number**—Enter the phone number of the insurance company used to verify patient’s insurance.
  - **Contact Person**—Enter the name of the person who provided the verification information.
  - **Annual Deductible**—Enter the amount of the annual deductible that the patient is responsible for, check the appropriate box and enter any amount left owed by the patient to the right of the boxes. Complete the YTD deductible information in the same manner.
  - **Precertification Required**—Check the appropriate box. If precertification is required, please follow the precertification policy.
  - **Referral Required**—Check the appropriate box. If a referral is required, please make sure that the patient is aware that a referral is required. Put a check in the appointment book by the patient’s name. When the patient arrives for the appointment, make sure to obtain the referral.
  - **Co-payment Required**—Verify that the patient’s insurance requires a co-payment, and verify if that co-payment is required each daily treatment and/or clinic visit. Enter that amount in the space provided.
3. Once you have verified the primary insurance coverage, contact the secondary insurance company to verify coverage. Complete the following sections:
- **Phone Number**—Enter the phone number of the insurance company used to verify patient’s insurance.
  - **Contact Person**—Enter the name of the person who provided the verification information.
  - **Annual Deductible**—Enter the amount of the annual deductible that the patient is responsible for; check the appropriate box and enter any amount left owed by the patient to the right of the boxes. Complete the YTD deductible information in the same manner.

## FINANCIAL ADVOCACY NETWORK

- **Precertification Required**—Check the appropriate box. If precertification is required, please follow the precertification policy.
  - **Referral Required**—Check the appropriate box. If a referral is required, please make sure that the patient is aware that a referral is required. Put a check in the appointment book and/or computer log by the patient's name. When the patient arrives for the appointment, make sure that he or she presents the referral.
  - **Co-payment Required**—Verify that the patient's insurance requires a co-payment and verify if that co-payment is required for each daily treatment and/or clinic visit. Enter that amount in the space provided.
4. Once the verification process has been completed, the original copy should be kept in the patient's medical record behind the patient's demographic form.

***Under no circumstances should the patient be treated prior to verification of the primary and secondary insurance.***