ASSOCIATION OF COMMUNITY CANCER CENTERS

FINANCIAL ADVOCACY NETWORK

INSURANCE VERIFICATION FORM

Update ❑ **New** ❑

Patient Name: _____ ID/SSN #: _____

Patient Insurance ID (if different from above): _____ Group Policy #: _____

Insurance Company: _____

Primary Insurance? _____ Secondary? _____ Tertiary? _____

Authorization/referral #_____ Name of Contact_____

Date/Time of Auth: _____

Phone/Fax/Address for Auth: _____

Effective Date: _____/_____/_____ PCP: _____ Tel #: _____

Specific Pharmacy Requirement: _____ ❑Mail order

Co-insurance/Co-pay: _____ Cap for drugs or diagnosis: $_____

Catastrophic Coverage or Stop-loss _____ When? _____

Medicare? Card Number: _____ Effective: ____/____/____

❑Part A ❑Part B **Medicare HMO?:** _____

Medicare Supplement? ❑Yes ❑No Medigap Plan? _____

Does policy include a Deductible? ❑Yes ❑No Coinsurance? ❑Yes ❑No

Prescription Drugs? ❑Yes ❑No

Medicaid? ❑Yes ❑No Pending? _____ Spend Down? ❑Yes ❑No

Share of Costs? _____ Spend Down Amount $_____

Referral to financial counselor? _____

Hospice Benefits Enacted? _____

Comments_____

_____

Conclusion: ❑Patient Has Coverage ❑Patient Has No Coverage ❑Research Necessary