ICD-10 INSURANCE VERIFICATION REQUEST FORM

SELECT ONE: ⇨ **Home Health Patient:** ☐ **MED B/Com. INS Patient:** ☐ **Home TX** ☐ **PEP** ☐

New Patient Add: ☐ **Re-Admit/New Episode:** ☐ **Discipline for EMR entry: PT** ☐ **OT** ☐ **ST** ☐

Facility Name _____ **Facility Code**_____

Facility Phone: _____ **Facility Fax:** _____

If Home Health Patient **HH Agency Name**_____ **HH Agency code**_____

___/____/___ _____ _____

Onset Date **Ref. Physician: Last Name, First Name** **Ref Physician NPI #**

Treating Therapists:

1(PT) _____ **2(OT)** _____ **3(ST)** _____

CC/PD name: _____

Registration Patient Information:

_____ M☐ F☐ _____ _____/_____/_____

PATIENT NAME: **Last, First, Middle** **Sex** **Social Security #** **Date of Birth**

_____

MAILING ADDRESS: **Number,** **Street,** **City,** **State,** **Zip Code**

_____ _____ _____

AREA CODE + HOME PHONE NUMBER **AREA CODE+WORK PHONE NUMBER** **EMAIL**

Power of Attorney/Responsible Party Information:

_____ _____

NAME: Last, First, Middle **Relationship to Patient**

_____

MAILING ADDRESS: Number, Street, City, State, Zip Code

(_____) _____-_____ (_____) _____-_____ (_____) _____-_____

AREA CODE + HOME PHONE NUMBER **AREA CODE+WORK PHONE NUMBER** **CELL PHONE**

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Insurance Information:

_____ _____

PRIMARY INSURANCE COMPANY: Company Name and Mailing Address (Street, City, State, Zip Code) **GROUP NUMBER**

_____ _____/___/_____ _____

CERTIFICATE/ POLICY NUMBER EFFECTIVE DATE INSURANCE CO PHONE NUMBER

_____ _____

SECONDARY INSURANCE COMPANY: Company Name and Mailing Address (Street, City, State, Zip Code) **GROUP NUMBER**

_____ _____/___/_____ _____

CERTIFICATE/ POLICY NUMBER EFFECTIVE DATE INSURANCE CO PHONE NUMBER

Entire form must be completed all required for EMR –ICD 10 System

Return to Corporate Billing using your assigned Billing Efax number or Email using Internal Email to: efax