

Insurance Verification & Authorization

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|---------------|----------------|-------------------------|---------------|----------------------|
| Patient Name | DOB | Medicare # | SOC Date | Episode Dates |
| Plan Type | Insurance Name | Policy Number | Group# | Effective/Term Dates |
| Insureds Name | DOB | Relationship to Insured | Employer Name | |

Annual Benefits Verification

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|--|--|--|
| In Network | Out of Network | In-Network Waiver Req: YES or NO |
| Deductible:\$ _____ Remaining:\$ _____ | Deductible:\$ _____ Remaining:\$ _____ | Deductible:\$ _____ Remaining:\$ _____ |
| Co-Insurance:\$ _____ Remaining:\$ _____ | Co-Insurance:\$ _____ Remaining:\$ _____ | Co-Insurance:\$ _____ Remaining:\$ _____ |
| Home Health Visit Max #: _____ | Home Health Visit Max#: _____ | |
| Visits Used: _____ | Visits Used: _____ | |
| PCP: _____ | PCP: _____ | |
| Referral Required: YES or NO | Referral Required: YES or NO | |
| Benefits Verified By: _____ | Date/Time: _____ | Insurance Rep & Phone: _____ |

Pre-Authorization/Pre-Certification

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|--------------------------------------|------------------|----------------|
| Authorized Date Range: | Authorization #: | Date/Time Recd |
| Services Requested/Number of Visits: | Representative: | Phone#: |

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|---|--|--|------------------------------------|-------------------|--------------------|
| Skilled Nursing 0551 RN G0299/G0493/G0495/G0162 LVN G0300/G0494/G0496 | Physical Therapy 0421 G0151/G0157/G0159/G2168 | Occupational Therapy 0431 G0152/G0158/G0160 | Speech Therapy 0441 G0153/G0161 | MSW 0571 G0155 | Aide 0561 G0156 |
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Comments:
