Medical Insurance Verification of Eligibility and Benefits

Date: _____ Verified by: _____ Time of Call: _____

Patient Name: _____ DOB: _____

SSN: _____ Address: _____

Subscriber Name: _____ DOB: _____

SSN: _____ Subscriber #: _____

Employer: _____ Group #: _____

Insurance Co.: _____ Phone: _____

Claims Address: _____ Fax #: _____

_____ Call Ref. #: _____

Benefits

Effective Date: _____ Out of Network Benefits: Y N

Deductible: _____ Met to date: _____ Calendar Plan: _____

DME Deductible: _____ Met to date: _____ Calendar Plan: _____

Out of pocket: _____ Met to date: _____ Office Co-pay: _____

Agent Name/ID: _____ Pre-Cert. #: _____

Covered Benefits: **AOB:** Y N

Procedure	Code	PreCert	
Sleep Appliance	E0486	Y	% _____
Home Sleep Test	95806	Y	% _____

Post Op visits allowed only after: 30 days 60 days 90 days

Notes: _____

_____

_____

Provided by:
AAFE SLEEP
A Collaboration of the AAFE and STATDDS