

OrthoSource, Inc.  
Insurance Verification Form

Patient Name \_\_\_\_\_

Insured Name \_\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_\_

Group # \_\_\_\_\_

Auth./ Referral # \_\_\_\_\_ per \_\_\_\_\_

Policy/Member ID # \_\_\_\_\_

Claim # \_\_\_\_\_

Type of claim:    WC        MVA        PI/Liability        PPO        HMO        POS        Private

Bill to: Co. Name \_\_\_\_\_

Date Verified \_\_\_\_\_ by \_\_\_\_\_

Attention \_\_\_\_\_

Per \_\_\_\_\_

Address \_\_\_\_\_

Effective Date \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Co. Phone \_\_\_\_\_

Needed Information:    MD Prescription        HMO Referral        Pre-Authorization        Letter of Medical Necessity

Policy Information:        Deductible \$ \_\_\_\_\_ Met

Pt. Responsibility \_\_\_\_\_%        Out of Pocket Maximum \$ \_\_\_\_\_

Pt. Co-Pay \$ \_\_\_\_\_        (Payment Plan Amount \$ \_\_\_\_\_ per \_\_\_\_\_.)

Comments/Restrictions \_\_\_\_\_

\*\*\*\*\*

(Copy of Card)