Insurance Verification

Please complete all information below.

Patient Information

Today's Date: ______ DOB: ______

Patient's Name: ______ Phone: ______

Surgery Information

Surgery Date: ______

Surgeon: ☐ Dr. Bramwell ☐ Dr. Badger ☐ Dr. Boyer Tax ID: 91-2032378

Surgery Location: ☐ WIOC (91-2087449) ☐ EHMC (91-0844563) ☐ ESC (91-2032378)

Diagnosis: ______

Codes: ______

Primary Insurance Information

Primary Insurance: ______ Phone: ______

Subscriber Name: ______

Membership Number: ______ Group Number: ______

Insurance Contact Name: ______ Phone: ______

Policy Effective Date: ______

Assist Allowed: ☐ Yes ☐ No ☐ N/A

Pre-authorization required: ☐ Yes ☐ No Authorization Number: ______

	In Network	Out of Network
Deductible:		
Out-of-Pocket:		
Deductible Met:		
Out-of-Pocket Met:		
Physician Benefits:		
Facility Benefits:		

Secondary Insurance Information

Secondary Insurance: ______ Phone: ______

Subscriber Name: ______

Membership Number: ______ Group Number: ______

Insurance Contact Name: ______ Phone: ______

Policy Effective Date: ______

Assist Allowed: ☐ Yes ☐ No ☐ N/A

Pre-authorization required: ☐ Yes ☐ No Authorization Number: ______

	In Network	Out of Network
Deductible:		
Out-of-Pocket:		
Deductible Met:		
Out-of-Pocket Met:		
Physician Benefits:		
Facility Benefits:		

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Form 00011 – Rev. 021517