Maternity Care Program

Third Party Insurance Verification

To Whom It May Concern:
The following is a form seeking verification of health/medical insurance information – as required by Medicaid – for the following person. Please note that a release of information is included.

I, ______________________________give permission for the ____________________________
(patient's full name) (Insurance Company)
and/or Personnel Department of __________________________________to release the
following information concerning my insurance coverage to __________________________.

Patient Signature:_________________________________ Date:_____________________

PATIENT INFORMATION

Name ____Date of Birth_________________

Address____

City___________________________County____________________State________________

Zip____________________________SS#____

Name and Address of Insurance Company
____Phone ___________________

Policyholder's Name____

Relationship to atient____

Policy # ____

Other Pertinent Data____

TO BE COMPLETED BY INSURANCE COMPANY/PERSONNEL DEPARTMENT

Does the above named person have maternity coverage? Yes____No____

When did coverage begin? Month____Day____Year____End Date: Month____Day____Year____

Is Pre-Certification required? Yes_____No_____

Additional Comments: ____

Signed:
____

Where should claims be filed?
____
____

Telephone Verification: Yes____No____Date___________ Made by:______________________

Please return form within 30 days to: ____

If you have any questions, please call____
(If possible, please include copy of policy booklet or pertinent sections. Thank you for your assistance.)