INSURANCE QUESTIONNAIRE

Patient's Name____
(Please Print)

Name of insurance company____
Policy or ID #

PRIOR TO YOUR SCHEDULED APPOINTMENT IT IS YOUR RESPONSIBILITY TO VERIFY INSURANCE COVERAGE AND YOUR POLICY BENEFITS. BEFORE YOUR HOSPITAL ADMISSIONS, THE FOLLOWING INFORMATION MUST BE RECEIVED IN OUR OFFICE.

Name of insured:_________________________________Insured SSN:________________________

Phone number to verify insurance coverage:____

Relation to patient____

Call your insurance carrier and inquire regarding: Prenatal Care and Delivery.
We will bill Globally at time of delivery. The code is 59400

1. Amount of your policy's deductible____
2. The amount of your responsibility/co-payment._______________(Example: insurance may cover 80% of surgical fees after the deductible; therefore, the patient is then responsible for the remaining 20%). For physician only, not hospital.
3. **PREADMISSION AUTHORIZATION:** This requirement authorizes the number of days a patient is allowed to stay in the hospital. Telephone authorization needs to be obtained prior to any hospital admission. Please provide the toll free phone number ______________________________.
4. If your insurance coverage is relatively new, be sure to know whether or not you have a waiting period before the insurance carrier will pay benefits—or whether your condition will be considered "pre-existing" and NO insurance benefits allowed.

Date____________ Signature____