

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
(Work place of insurance holder)
information concerning my insurance coverage to _____.
(name of Primary Contractor)
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 Patient _____
Policy # _____
Other Pertinent Data _____

TO BE COMPLETED BY INSURANCE COMPANY/PERSONNEL DEPARTMENT
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Does the above named person have maternity coverage? Yes ___ No ___
When did coverage begin? Month ___ Day ___ 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)