

## 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 \_\_\_\_\_

<b>TO BE COMPLETED BY INSURANCE COMPANY/PERSONNEL DEPARTMENT</b>
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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)