integrapartners

Tel 718.369.0012 Fax 718.287.1229
NPI: 1962502229
NY Tax ID#: 421685996 NJ Tax Id #:27-2952320

Remember to check the ***Payer Remittance List*** to see if the plan you are billing to is contracted for DME, O&P only, or for both. Authorization is not a guarantee of payment, and non-contracted items will not be paid. The Payer Remittance List and other forms can be found at *www.accessintegra.com*.

INSURANCE VERIFICATION FORM

For accurate claim submissions, insurance policies should be re-verified every time a patient is serviced.

Patient: DOB:

Policy Holder: DOB:

Insurance Plan: **ID#:**

Managing Entity (HIP, GHI, and Aetna Only):

Rep Name (1st name and last initial): **Date & Time of Call*:**

Effective Date: Termination Date:

Coordination of Benefits (COB) - Circle One: PRIMARY SECONDARY

Name of primary insurance (if applicable): _____

Does the patient have DME/O&P benefits? ***DME***: YES NO ***O&P***: YES NO

Is/Are the service(s) you are providing covered? YES NO

Copay for DME/O&P? YES NO Amount: $

Co-insurance for DME/O&P? YES NO Percentage%:

Deductible for DME/O&P? YES NO

Amount per Calendar Year: $ Met YTD: $

Prior Auth required for DME/O&P YES NO

If auth depends on code, what codes require auth? List:

_____

_____

Special directions for submitting auth requests**:

_____

_____

Claims Address: _____

Please obtain a call reference number if available. **Please remember to submit claims exactly as authorized.

Verified By: _____ Date: _____ Call Reference#:_____