Crossway, Inc.

Patient Information

Insurance Verification

A. PATIENT INFORMATION	
Patient's Name:	DOB:
Patient's Address:	
City, State, Zip:	
Home Phone:	Work Phone:

B. PRIMARY INSURANCE INFORMATION:	
Insured's Address if different than above:	Effective Date of Policy:
Insured Member's Name:	SS#:
Insured's Employer:	DOB:
Insurance Carrier:	Plan Type (PPO, Blue E, etc):
Member or Medicaid ID #:	Group #:
Insurance Mailing Address:	Phone No.:

C. SECONDARY INSURANCE INFORMATION	
Insured Member's Name:	SS#:
Insured's Employer:	DOB:
Insurance Carrier:	Plan Type:
Member or Medicaid ID #:	Group #:
Insurance Mailing Address:	Phone No.:

D. DIAGNOSIS INFORMATION		
Diagnosis Code #1:	Diagnosis Code #2:	Diagnosis Code #3:

Onset Date: If Medicaid, Carolina Access #:

E INSURANCE COVERAGE LIMITATIONS/ABILITIES	
Referral required by primary care physician: Y/N	Effective Date of Policy:
Pre-authorization Required:	Deductible Amount:
Providers Care Covered:	Not Covered/Co-pay:
Limitations $$ Amount:	Number of Visits Permitted:

DISCLAIMER: VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT BY THE INSURANCE COMPANY. PATIENT IS RESPONSIBLE FOR SERVICES RENDERED BY CROSSWAY, INC. REGARDLESS OF THE ABOVE FINDINGS.