

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.