

INSURANCE

Insurance Verification & Authorization

Please complete fully and attach copies of all current insurance cards (front and back).

WHY WE NEED THIS

We use this information to verify your benefits, identify prior authorization requirements, calculate your estimated cost share, and process claims accurately. Bring all current insurance cards to your visit so we can scan both sides.

Patient Identifiers

PATIENT NAME (LAST, FIRST, MI)

DATE OF BIRTH

SEX

Primary Insurance

INSURANCE COMPANY

 PLAN TYPE (HMO, PPO, EPO, POS,
MEDICARE, MEDICAID, TRICARE)

MEMBER ID

GROUP #

POLICY EFFECTIVE DATE

RXBIN / RXPCN

MEMBER SERVICES PHONE (ON CARD)

PROVIDER SERVICES PHONE

CLAIMS ADDRESS

SUBSCRIBER / POLICYHOLDER (IF NOT PATIENT)

SUBSCRIBER NAME (LAST, FIRST, MI)

DATE OF BIRTH

RELATIONSHIP TO PATIENT

SUBSCRIBER EMPLOYER / PLAN SPONSOR

SUBSCRIBER ADDRESS (IF DIFFERENT FROM PATIENT)

Secondary Insurance (if applicable)

INSURANCE COMPANY

PLAN TYPE

MEMBER ID

GROUP #

EFFECTIVE DATE

MEMBER SERVICES PHONE

SUBSCRIBER NAME (IF NOT PATIENT)

SUBSCRIBER DOB

RELATIONSHIP

Other Coverage & Special Circumstances

 Workers' compensation (provide claim # below)

 Auto / liability claim (motor vehicle)

 VA benefits

 Indian Health Service (IHS)

 HSA / FSA card on file

 None of the above

CLAIM # / ADJUSTER / NOTES (IF APPLICABLE)

Assignment of Benefits & Authorization to Bill

I authorize Rocket City Clinics to bill my insurance carrier(s) listed on this form for services rendered to me. I authorize my insurance company (and any responsible third-party payer) to pay benefits directly to Rocket City Clinics. I authorize Rocket City Clinics to release medical and other information necessary for processing my insurance claims, prior authorizations, and appeals.

Financial Responsibility Acknowledgment

- I am ultimately responsible for any balance not paid by my insurance, including copays, deductibles, coinsurance, and non-covered services.
- Verification of benefits is not a guarantee of payment. Coverage is determined by my plan.
- If my insurance is terminated, denies a claim, or determines a service is not covered, I am responsible for payment in full.
- I will notify Rocket City Clinics promptly of any changes to my insurance coverage.

For Office Use Only

VERIFICATION TRACKING

VERIFIED BY (STAFF NAME)

DATE VERIFIED

METHOD

 Phone

 Portal

 Clearinghouse

REFERENCE / CONFIRMATION #

REP SPOKEN WITH

BENEFITS SUMMARY

ITEM	PRIMARY	SECONDARY
In-network status	<input type="checkbox"/> INN <input type="checkbox"/> OON	<input type="checkbox"/> INN <input type="checkbox"/> OON
Plan year deductible / met to date	\$ _____ / \$ _____	\$ _____ / \$ _____
Out-of-pocket max / met to date	\$ _____ / \$ _____	\$ _____ / \$ _____
Office visit copay (PCP / Specialist)	\$ _____ / \$ _____	\$ _____ / \$ _____
Coinsurance %	_____ %	_____ %
Telehealth coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Behavioral / mental health	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spravato® / esketamine	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> PA req	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> PA req
Stimulant medication coverage (Sched II)	<input type="checkbox"/> Yes <input type="checkbox"/> PA req	<input type="checkbox"/> Yes <input type="checkbox"/> PA req

PRIOR AUTHORIZATION STATUS

PA REQUIRED FOR

PA SUBMITTED DATE

PA STATUS

 Approved

 Pending

 Denied

AUTHORIZATION # / NOTES

PATIENT SIGNATURE (OR AUTHORIZED REPRESENTATIVE)

DATE