Allied

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Other Insurance Verification Form

Employee: _____

Insured's SS#: _____

Patient: _____

Claim #: _____
Can be any pended/denied claim number for the patient

Group #: _____

Date: _____

Group Name: _____

Are you married? ☐ Yes ☐ No Is your Spouse Employed? ☐ Yes ☐ No

If Yes, Spouses Employers Name: _____

Spouses Employers address: _____

Does your spouse have Medical/Dental coverage with this employer? ☐ Yes ☐ No

Is your spouse eligible to have Medical/Dental coverage with this employer? ☐ Yes ☐ No

Is you spouses coverage single or family coverage? _____

If yes to family coverage – what is the spouses birthdate? _____

If yes: Name, Address and telephone number of insurance. _____

_____

Spouses Insurance Effective date: _____

Did your spouse have Medical/Dental coverage with this employer?* ☐ Yes ☐ No

Spouses Insurance termination date: _____

Which natural parent has court appointed Financial responsibility for children?** ☐ Mother ☐ Father

Which natural parent has the court appointed custody of children?** ☐ Mother ☐ Father

* A letter of credible coverage must be submitted from the previous carrier showing the termination date.
** No divorce decree is required

Notes:

Office Use Only

☐ Denied Information Received

☐ Missed Releases

☐ First time Receiving Information

CSR: _____

Adjusters initials: _____

Caller: _____

Caller's #: _____