Deak Vein NJ Clinic

In Office Laser Vein Treatment

Verification of Eligibility and Benefits Form

Today’s Date: __________

Patient Name: ____

Date of Birth: ___________

Social Security Number: __________________________________

Primary Insurance: _______________________________________

Phone Number: ____

¨ PPO In Network **¨ PPO Out of Network** **¨ Commercial**

Plan Identification Number: _______________________________

Group Number:____

Insured’s Name: ____

Insured’s SS# ____

Insurance Effective Date: ___________________________________

Deductible Amt: $____

Pre-Existing Conditions? ___________________________________

Has the Deductible Been Met This Year? ¨ Yes ¨ No

Is it a Calendar Year (if no, note renewal date) ¨ Yes ¨ No ______

Copay for Medical / Office Visits: $__________________________

	Approved Facilities	Pre-Authorization Needed (Y/N)	If Deductible Different Note $ and Max.	Limited # of Visits or Dollar Max?
Laboratory				
Diagnostic Tests				
Great Saphenous Vein Ablation, VenaCure				

Where Do We Send the Claim?____

____

I Spoke With: ___________________________ Direct Line: _________________________

Employee Initials: _____________