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Birth__ Well Woman__

Insurance Eligibility Verification Form

DATE _____

Client's Name

Birth Date

Due Date of Birth

Client's Address

Phone Number

G__ P__ LMP__

Insurance Company

Phone Number

Claims Address

Rep Name

Time

ID or Policy Number

Group Number

Plan Name

Name of Insured

Insured's Date of Birth

Relationship to Client

Employer of Insured

-----**DO NOT WRITE BELOW THIS LINE**-----

___ PPO ___ EPO ___ QPOS ___ POS ___ Standard Medical ___ Self Funded Plan

Birth Center Y___% N__

Home Birth Y___% N__

Midwife? Y___% N__

\$ Deductible

% of Deductible met

Out of Pocket

Effective Date

Ultrasounds? Y___ N___ Timely Filing Deadline _____ Global Billing + Initial___ or Itemized Billing_____

Precert Necessary for Homebirth? Y__N__ Precert # _____ Precert Phone# _____

NOTES: _____

