McLAREN THUMB REGION
INSURANCE VERIFICATION

Patient:	DOB:	Date of Surgery:
Dx:	Procedure:	Doctor:
Date of Accident:	Location:	Pt. Home #:
Primary Carrier:	Policy:	Insured:
Secondary Carrier:	Policy:	Insured:
Where Employed:	Pre-Op:	

Benefits	Primary	Secondary	Third
Pre Existing Wait Period			
Effective Date			
Exclusions/Explain	YES / NO	YES / NO	YES / NO
Deductible			
Percentage Covered			
Life Time Max			
Remaining Benefits			
Claim Form Needed			
Second Opinion			
Out of Pocket		Pre-Cert	Y ____ N ____

Verified with (name)		
Phone #		
Date Verified		

Utilization Review		
Phone #		
Authorization #		
# Days Authorized		
Authorized by		

Patient Deductible _____ Paid on Surgery / Procedure Date

Advance Payment Required _____

Discussed with Patient on _____ By: _____