

**McLaren Print System Order**

**Order No: 85009 Reprint Previous Order No: 58046**  
**Order Date: 2024-04-27**  
**User: VICKI YAROCH**  
**Phone: 989-269-9521**

**Ship Location: MCLAREN THUMB REGION**  
**1100 S VAN DYKE**  
**BAD AXE, MI 48413**

**Forms**

**Quantity: 2500**  
**Paragon Dept No: 2210**  
**Dept Name: PULMONOLOGY**  
**Company Number: 530**

**Order Total Price: 75.50**

**Item Number: 210.116**  
**Item Description: Insurance Verification**  
**Revision Date: 06/2018**  
**Print: 1 sided black and white**  
**Paper: 20# White Text**  
**Size: 8.5 x 11**  
**Fold:**  
**Finish: None**  
**Drill: None**  
**Misc Info: SS; BLACK; BOND PAPER**

MCLAREN THUMB REGION  
INSURANCE VERIFICATION

Patient: _____		DOB: _____	Date of Surgery: _____
Dr: _____		Procedure: _____	Doctor: _____
Date of Accident: _____		Location: _____	Pl. Home #: _____
Primary Center: _____		Policy: _____	Insured: _____
Secondary Center: _____		Policy: _____	Insured: _____
Where Employed: _____		Pre-Op: _____	

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

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Verified with (name): \_\_\_\_\_

Phone #: \_\_\_\_\_

Date Verified: \_\_\_\_\_

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Utilization Review

Phone #: \_\_\_\_\_

Authorization #: \_\_\_\_\_

# Days Authorized: \_\_\_\_\_

Authorized by: \_\_\_\_\_

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Patient Deductible: \_\_\_\_\_ Paid on Surgery / Procedure Date: \_\_\_\_\_

Advance Payment Required: \_\_\_\_\_

Discussed with Patient on: \_\_\_\_\_ By: \_\_\_\_\_

210 116 06 18