Insurance Verification

Please complete all information below.

ORTHOWASHINGTON

Patient Information

Today's Date: _____ DOB: _____

Patient's Name: _____ Phone: _____

Surgery Information

Surgery Date: _____

Surgeon: ☐ Dr. Bramwell ☐ Dr. Badger ☐ Dr. Boyer Tax ID: 91-2032378

Surgery Location: ☐ WIOC (91-2087449) ☐ EHMC (91-0844563) ☐ ESC (91-2032378)

Diagnosis: _____

Codes: _____

Primary Insurance Information

Primary Insurance: _____ Phone: _____

Subscriber Name: _____

Membership Number: _____ Group Number: _____

Insurance Contact Name: _____ Phone: _____

Policy Effective Date: _____

Assist Allowed: ☐ Yes ☐ No ☐ N/A

Pre-authorization required: ☐ Yes ☐ No Authorization Number: _____

	In Network	Out of Network
Deductible:		
Out-of-Pocket:		
Deductible Met:		
Out-of-Pocket Met:		
Physician Benefits:		
Facility Benefits:		

Secondary Insurance Information

Secondary Insurance: _____ Phone: _____

Subscriber Name: _____

Membership Number: _____ Group Number: _____

Insurance Contact Name: _____ Phone: _____

Policy Effective Date: _____

Assist Allowed: ☐ Yes ☐ No ☐ N/A

Pre-authorization required: ☐ Yes ☐ No Authorization Number: _____

	In Network	Out of Network
Deductible:		
Out-of-Pocket:		
Deductible Met:		
Out-of-Pocket Met:		
Physician Benefits:		
Facility Benefits:		

Form 00011 – Rev. 021517