NEW INSURANCE FORM

Today's Date: _____ **Completed by** ☐ **Patient** ☐ **Staff/Clinician Initials** _____

BELOW INFORMATION - To be completed by Responsible Party/Patient

List below *ALL* family members affected by this change of insurance that are seen at PRA!!

1._____ **2.**_____
Patient first name last date of birth Patient first name last date of birth

3._____ **4.**_____
Patient first name last date of birth Patient first name last date of birth

Effective Date of policy: _____-_____-_____

Check ***ALL*** clinicians affected by this insurance change

☐ **Resis** ☐ **Woods** ☐ **Paul** ☐ **Fabsik** ☐ **Bard** ☐ **McFaul** ☐ **Chang**
☐ **Nawaz** ☐ **Rhee** ☐ **Gorman** ☐ **Komarovsky** ☐ **Wallen** ☐ **Astleford**

☐ **Therapist(s) List Name(s):** _____

Do you want a call regarding new benefits? If Yes - Phone #: (____) _____-_____

Relation to the Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Policy Holder's Name: _____ **Policy Holder's D.O.B**: _____-_____-_____

Policy Holder SS# _____-____-_____ **Policy Holder Phone #: (_____) _____-_____**

Name of Insurance: _____ **ID#**_____ **Group #**: _____

Insurance Phone #: (_____) _____-_____ Policy Holder Place of Employment: _____

Secondary Insurance? ☐ **No** ☐ **Yes – Complete: 2nd Insurance Name:** _____

ID #:_____ **Group #:**_____ **2nd Insurance Phone #: (_____) _____-_____**

Failure to complete ALL this information may result in insurance not being changed in our system timely, could result in services denied if precertification was not obtained prior to change of insurance and may result in full payment due by patient! 10/1/20

STAFF DOCUMENTATION ONLY BELOW

Returning Patients – **Demographics on EMR are verified and accurate by front desk?** ☐Yes If NO do not schedule

Benefit Specialist – Calls Returning Pts/Transfers w/Benefits Date: _____/____/_____ Contact Type ☐ LM ☐ TTP live

MD – Next Appointment _____-_____-_____ **MD** – Last Appointment _____-_____-_____

Reviewed ALL account in BILLING? ☐Yes ☐No (others who need updated benefits)

Date Up-loaded into EMR _____-_____-_____ New Benefits for Therapist Up-Loaded: ☐ EMR ☐ Sharefile

Benefits done by: _____ **Date Completed**: _____-_____-_____

Date Billers notified/emailed: _____-_____-_____ **Date Therapist called with benefits**: _____-____-_____

Billers – contact patient for any issues with new insurance ☐ Yes ☐ No – no issues with benefits

Billers – For new insurance – Any Past DOS need tyo be rebilled? ☐ Yes ☐ No ☐ N/A

Benefits Specialist – Accounts updated in all EMR Date:___-___-_____ ☐ Sticky note ☐ CoPay/Ded ☐ Ins

Billers emailed: ☐ Susan ☐ Heather ☐ Jennifer ☐ Amy ☐ Brittany ☐ Michelle M ☐ Other_____

Comments:

Staff Completing Form: _____ **DATE**: _____