

NEW INSURANCE FORM

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

- Verbal
 Email
 Portal

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. _____ Patient first name last date of birth	2. _____ Patient first name last date of birth
3. _____ Patient first name last date of birth	4. _____ Patient first name last date of birth

Effective Date of policy: _____ - _____ - _____

Check ALL clinicians affected by this insurance change

- Resis Woods Bateman Fabsik Bard McFaul Chang Va
 Nawaz Rhee Komarovskiy Wallen Astleford _____

Therapist(s) List Name(s): _____

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

Patient 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 #: (____) _____ - _____

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

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!

STAFF DOCUMENTATION ONLY BELOW

MD - Next Appointment _____ MD - Last Appointment _____

Benefit Specialist

- Reviewed ALL accounts in BILLING? Yes No (other patient accounts who need benefits updated)
- Date Benefits up-loaded into EMR/completed Benefits done by: _____
- Date Benefit Specialist notified Biller: Email TEAMS Both
- Billers emailed: Susan Heather Jennifer Amy Brittany Michelle M Other _____
- Date Benefit Specialist notified therapist: Email Voicemail TEAMS
- Benefits Specialist - Accounts updated in all EMR Date: _____
 Sticky Note Insurance Active / Old CoPay / Co-Insurance / Deductible Remove Old Notes!

Billers

- Contact patient and document in EMR for any issues with new insurance
 Yes No - no issues with benefits Patient requested a call
- For New Insurance - Any past DOS need to be rebilled? Yes No N/A
- Documented calls, lapses issues in EMR Yes None needed

Comments:

Staff Completing Form: _____ DATE: _____