advent
REHABILITATION

Auto Benefit Verification

Patient: _____ Claim #: _____

Adjustor: _____ Phone: _____

Is this an Open Claim? ☐ Yes ☐ No

Date of Injury: _____

Diagnosis: _____
Are they paying for related treatment? ☐ Yes ☐ No

Is this a coordinated policy? ☐ Yes ☐ No
If yes, complete insurance verification section of form
What is the claims mailing address? _____

_____

_____

Deductable: _____
Do I have the correct claim number? ☐ Yes No: _____

Insurance Verification for Coordinated Policies

Insurance Carrier: _____ Phone: _____

Representative: _____ Claims Address: _____

Effective Date: _____ Contract Year: Calendar/Other _____

Number of Visits (combined/consecutive) allowed per contract year: _____

Copay per visit: _____. Out of Pocket Maximum per year: _____

Diagnosis: _____. Payable under plan? ☐ Yes ☐ No

Deductable: _____ Met for contract year?: _____

Preauthorized Required: ☐ Yes ☐ No Phone: _____ Representative: _____

Authorization Number: _____ Auth Dates From _____ to _____

Completed by: _____
Date: _____