INFUSION BENEFIT VERIFICATION

Date_____

PATIENT NAME:_____ **DOB**_____ **PROVIDER:**_____

J-CODE: _____ **ADMIN CODE:** _____ **OFFICE:** _____

BUY AND BILL: _____ **SPECIALTY PHARM:** _____ **DX:**_____

PRIMARY INS:_____	**SECONDARY INS:**_____
TEL#:_____	**TEL#:**_____
ID#:_____	**ID#:**_____
EFF DATE:_____	**EFF DATE:**_____
DED/ OOP:_____	**DED/ OPP:**_____
MET TO DATE:_____	**MET TO DATE:**_____
COINSURANCE:_____	**COINSURANCE:**_____
INS REP:_____	**INS REP:**_____
REF#:_____	**REF#:**_____
PA REQ: Y_____ **N**_____	**PA REQ: Y**_____ **N**_____
PA COMPANY:_____	**PA COMPANY:** _____
TEL/ FAX#:_____	**TEL/FAX#:**_____
PA REP:_____	**PA REP:**_____
PA#_____	**PA#**_____
VALID DATES:_____	**VALID DATES:**_____

NOTES:_____
_____
_____

Name_____