INSURANCE VERIFICATION FORM

Patient's Name: Date:

PRIMARY INSURANCE INFORMATION		
Policy Holder's Name:	Insurance Company Name:	
Policy Holder's ID Number:	Patient's ID Number:	
Do you Work? – ☐ YES ☐ NO	Group Number:	DOB:
Company Address:	Company Phone Number:	

TYPE OF INSURANCE PLAN				
MEDICAID + HMOs				
☐ Medicaid Forward	☐ Molina Medicaid	☐ Anthem Medicaid	☐ UHC Community Plan	
☐ NHP Medicaid	☐ MHS Medicaid	☐ iCare Medicaid	☐ Children's Community HP	
COMMERCIAL				
☐ Humana	☐ UHC Commercial	☐ UHC EAP	☐ Molina Marketplace	
☐ Cigna	☐ BCBS Commercial	☐ Together W/ CCHP	☐ United Choice One	
☐ UMR	☐ All Savers (UHC)	☐ Beacon Health (EAP)	☐ Other:	

SECONDARY INSURANCE INFORMATION		
Policy Holder's Name:	Insurance Company Name:	
Policy Holder's ID Number:	Patient's ID Number:	
Do you Work? – ☐ YES ☐ NO	Group Number:	DOB:
Insurance Company Address:	Company Phone Number:	

TYPE OF INSURANCE PLAN			
MEDICAID + HMOs			
☐ Medicaid Forward	☐ Molina Medicaid	☐ Anthem Medicaid	☐ UHC Community Plan
☐ NHP Medicaid	☐ MHS Medicaid	☐ iCare Medicaid	☐ Children's Community HP
☐ Other:			
COMMERCIAL			
☐ Humana	☐ UMR	☐ UHC EAP	☐ Molina Marketplace
☐ BCBS Commercial	☐ All Savers (UHC)	☐ Cigna	☐ United Choice One
☐ UHC Commercial	☐ Together W/ CCHP	☐ Beacon Health (EAP)	☐ Other:

NON-REPORTED ☐

SEE ADDITIONAL NOTES ☐

INCLUDE A COPY (FRONT & BACK) of INSURANCE CARD & IDENTIFICATION

*****Good Faith Estimate is available upon request*****

8440 West national Ave. West Allis, WI 53227 | 414-405-1682 | www.miraclecounseling.org