WBS Medicare Insurance Verification Form

Patient Name: _____ Patient DOB: _____

Patient Address: _____

Medicare#: _____

Doctor's Office: _____

Medicare Verification Information

Person Spoke To: *Automated System* Date: _____ Effect. Date: _____

Yearly Deductible *$203* Amount Met $_____ Claims paid @ *80%*

Supplemental Insurance Verification Information

Insurance Company Name: _____ ID: _____

Person Spoke To: _____ Date: _____ Effect. Date: _____

Crossover Plan in Effect? Yes / No Follows Medicare Guidelines? Yes / No

Covers Medicare Deductible? Yes / No Covers Medicare Coins? Yes / No
Claims Address: _____

If the supplemental plan has benefits that are different from standard Medicare Supplement plans, then an additional verification sheet will be attached with detailed benefits.

Will an additional verification sheet be attached to this fax? Yes / No