Franklin Surgical Center Patient Insurance Verification

Name:____ If, Minor, Parent's Name______________________________

Address:____

Home Phone:__________________________________ Cell :____

Work Phone:___________________________Patient DOB:__________ Age:______ Sex: ( ) Male ( ) Female

SS#____________________________________ Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed

E-mail address:____

Patient Employer Name:_________________________________ Patient Employer Phone______________________

Occupation:____________________Emergency Contact Name/Phone#_____________________________________

IF INSURANCE CARD PROVIDED PLEASE COMPLETE LINES 1 AND 2 ONLY IN PRIMARY AND SECONDARY INSURANCE SECTION

Primary Insurance Company

1.Policy holder name & relationship to patient:__________________________( ) Self ( ) Spouse ( ) Parent ( ) Other

2. Policy holder SS# and DOB:____

Insurance Company Name& Phone #____
Insurance Company Address:____
Policy ID and Group #____

Secondary Insurance Company

1.Policy holder name & relationship to patient:__________________________( ) Self ( ) Spouse ( ) Parent ( ) Other

2. Policy holder SS# and DOB:____

Insurance Company Name& Phone #____
Insurance Company Address:____
Policy ID and Group #____

ACCIDENT INFORMATION

Type ( ) Workers Comp ( ) Auto ( ) Other____________________ Accident Date____________________________

Carrier Name Address & Phone#____

Adjuster Name:_________________________________ Claim#____

Patient Signature :____________________________________Date:____

Franklin Surgical Center Insurance Verification Medicare Patients

Please answer the following questions and circle your answer:

		Yes	No
1.	Are you participating in a Medicare replacement program? **(If yes, no need to proceed to other questions).**	Yes	No
2.	Are you 65 or >, and unemployed? **(If yes, please provide retirement date, no need to proceed to other questions.**	Yes	No
	2A. Retirement date ______________________		
	2B. Are you receiving benefits from a black lung program, Veterans Affairs, Work related accident, non-work related accident, Government Research Program (GRP) or auto accident?	**Yes**	No
3.	Are you 65 or >, and covered by a group health plan through current Employer or spouses current employment?	Yes	No
	3A. < 20 employees **(If yes, no need to proceed to other questions)**	Yes	No
	3B. > 20 employees	**Yes**	No
4.	Are you <65 and disabled, and covered by a group health plan through a family members current employer?	Yes	No
	4A. <100 employees **(If yes, no need to proceed to other questions)**	Yes	No
	4B. > 100 employees	**Yes**	No
5.	Are you 65 or >, and disabled and covered by Medicare or COBRA? **(If yes, no need to proceed to other questions)**	Yes	No
6.	Do you have ESRD and a group health plan or COBRA ?	Yes	No
	6A. > 30 Months **(If yes, no need to proceed to other questions)**	Yes	No
	6B. < 30 Months	**Yes**	No

Patient Signature: ______________________________

Date: ______________________________

SCA Teamate Signature: ______________________________