INSURANCE VERIFICATION WORKSHEET

Verifying your insurance coverage is important! Please complete the following form by calling your insurance company or Human Resources Department *BEFORE* your first visit!

YOU WILL NEED THE FOLLOWING INFORMATION BEFORE CALLING:

Patient Name _____ Patient Date of Birth _____

Insured's Name _____ Insured's Date of Birth _____
Insured's SS# _____
Insurance Carrier _____ Insurance Phone Number _____
Insured's Group # _____ Insured's Policy # _____

CALL YOUR INSURANCE COMPANY TO DETERMINE BENEFITS:

DATE OF CALL: _____

SPOKE WITH:_____ CONFIRMATION #_____

Insurance Effective Date: _____

Are Maternity Benefits included in your plan? Yes ____ No____

Is West Suburban Midwife Associates in-network? Yes ____ No____
In-Network: BC/BS PPO, Blue Choice Select, Cigna, Aetna, Humana. Other: Use Tax ID 36-4387686 to determine network status.
Out of Network: United Healthcare, Mail Handlers Benefit, PHCS, Beech Street. See worksheet below to determine benefits

Are "**Certified Nurse-Midwives**" covered on your benefits plan? Yes ____ No____

Pre-certification needed prior to admission? Yes ____ No____ Upon admission? Yes ____ No____

Professional Fees	**In Network**	**Out of Network** (Request "Gap Exception")
Coverage Percentage (co-insurance)		
Co-Pay		
Deductible		
Has Deductible Been Met?		
Out of Pocket Maximum		

OPTIONAL: DO YOUR OWN ESTIMATED OUT OF POCKET EXPENSE…

***Global Fee* (estimated)** **$3550.00** Does NOT include labs, ultrasound, injections, and other charges
Less Deductible _____
Total _____
Multiply X ____% coinsurance _____
Total _____
Add back + deductible _____

TOTAL *ESTIMATED* OUT OF POCKET $_____ **Professional Fees.** Hospital/Facility Fees are separate