



Maternity Care Program Third Party Insurance Verification

To Whom It May Concern:

The following is a form seeking verification of health/medical insurance information – as required by Medicaid – for the following person. Please note that a release of information is included.

I, _____ give permission for the _____
(patient's full name) (Insurance Company)
and/or Personnel Department of _____ to release the
following information concerning my insurance coverage to _____.

Patient Signature: _____ Date: _____

PATIENT INFORMATION

Name _____ Date of Birth _____

Address _____

City _____ County _____ State _____

Zip _____ SS# _____

Name and Address of Insurance Company _____ Phone _____

Policyholder's Name _____

Relationship to patient _____

Policy # _____

Other Pertinent Data _____

TO BE COMPLETED BY INSURANCE COMPANY/PERSONNEL DEPARTMENT

Does the above named person have maternity coverage? Yes ___ No ___

When did coverage begin? Month ___ Day ___ Year ___ End Date: Month ___ Day ___ Year ___

Is Pre-Certification required? Yes ___ No ___

Additional Comments: _____

Signed: _____

Where should claims be filed?

Telephone Verification: Yes ___ No ___ Date _____ Made by: _____

Please return form within 30 days to: _____

If you have any questions, please call _____
(If possible, please include copy of policy booklet or pertinent sections. Thank you for your assistance.)