Telemedicine Insurance Verification Form

Date:______________________________ Time:______________ a.m p.m

Insurance:__________________________ Telephone #:______________________________

Rep Name and Reference Number :____

Pa ent First Name:_____________________________ Last Name:_____________________

Member ID:___________________________________ DOB__________________________

Plan Is:____

Effec ve Date:____

Plan Pays:___________________% after deductible of:

Deductible? Yes $____________ Met $____________

Family Ded? Yes $____________ Met $____________

Out of Pocket Maximum:

Individual OOP? Yes $____________ Met $____________ Remaining $_______________

Family OOP? Yes $____________ Met $____________ Remaining $_______________

Is Telemedicine covered? Yes No
(specifically code 99444)

If yes, requires authorization? Yes No

Is the GT modifier recognized? Yes No

Is there a limit of Telemedicine visits? Yes No

Would an evaluation and management code be covered with a GT modifier? Yes No

Timely Filing OON______________ Elec Payer ID #______________

Additional Notes:____