

■ Insurance Verification Checklist

Verify every patient's insurance BEFORE the visit — avoid surprise denials and billing headaches.

Insurance verification means checking that a patient's health insurance is active and will actually cover the services you plan to provide. Skipping this step is one of the top reasons medical claims get denied. Do this checklist at least 24–48 hours before every appointment.

1 · Gather Patient & Insurance Information

- **Collect patient's full legal name and date of birth**
This must match exactly what is on the insurance card. Even a small spelling difference can cause a denial.
- **Copy the front and back of the insurance card**
Keep a copy in the patient's file. Update it at every visit — insurance changes often.
- **Record the Member ID number**
This is the patient's unique ID with the insurance company. It goes on every claim.
- **Record the Group Number (if applicable)**
Most employer-based plans have a group number. Write it down — it is required on the claim form.
- **Note the insurance company name and payer ID**
The payer ID is a 5-digit number used to send electronic claims. It is NOT the same as the group number.
- **Get the name and date of birth of the subscriber (policy holder)**
The subscriber is the person who owns the insurance (could be the patient, a spouse, or a parent). You need their info too.

2 · Confirm Active Coverage

- **Call the insurance company OR use an eligibility portal to verify**
Most EHR systems have real-time eligibility (RTE) built in. Use it. If not, call the number on the back of the insurance card.
- **Confirm the policy is currently active**
Ask: 'Is this policy active as of today's date?' Get a reference number for the call.
- **Confirm the effective date of coverage**
Make sure coverage started before the date of service. New policies sometimes have a delay.

- **Check for any termination or end date**
Some patients have coverage that ends on a specific date (e.g., end of the month they lost their job).
- **Verify the patient's plan type**
Is it HMO, PPO, EPO, or POS? This affects whether the patient needs referrals and which providers they can see.

■ **TIP: Always get a Reference Number when you call the insurance company. Write it down. If there is ever a dispute, this number proves you verified.**

3 · Check Benefits for the Specific Services

- **Verify if your provider/practice is IN-NETWORK**
In-network means the insurance company has a contract with your practice. Out-of-network costs the patient much more — and sometimes you will not be paid at all.
- **Confirm the deductible amount and how much has been met**
The deductible is what the patient pays first before insurance kicks in. If it has not been met, the patient may owe the full amount.
- **Check the copay amount for this type of visit**
A copay is a flat fee the patient pays at the visit (e.g., \$30 for a specialist). Collect it before or during the visit.
- **Check the coinsurance percentage**
Coinsurance is the percentage the patient pays AFTER the deductible is met (e.g., 20%). Factor this into the patient's estimated cost.
- **Verify the out-of-pocket maximum**
Once the patient reaches this amount, insurance pays 100%. Helpful to know for patients with major medical needs.
- **Confirm coverage for the specific services planned**
Example: Is a preventive wellness visit covered at 100%? Is the planned procedure covered at all? Always check.
- **Check if a referral is needed from a PCP**
HMO plans usually require a referral from the primary care provider (PCP) before seeing a specialist.
- **Check if prior authorization is required**
Some services (MRI, surgery, certain drugs) need pre-approval. Without it, the claim will likely be denied.

4 · Secondary Insurance (If Patient Has Two Plans)

- **Ask the patient if they have a second insurance plan**
Many patients have both a primary and a secondary (supplemental) insurance. Always ask — do not assume.
- **Determine which plan is primary and which is secondary**
Use the COB (Coordination of Benefits) rules. The plan that pays first is primary. Bill primary first, then secondary.
- **Verify the secondary plan is also active**
Run the same eligibility check for the second insurance. An inactive secondary plan is the same as no plan.
- **Record the secondary payer ID and member ID**
You will need this when sending the secondary claim after the primary pays.

5 · Quick Reference — What to Write Down

Field	Where to Find It	Notes
Member ID	Front of insurance card	Required on every claim
Group Number	Front of insurance card	May not apply to individual plans
Payer ID	Insurance website / clearinghouse	5-digit electronic billing ID
Deductible Met	Insurance portal / phone call	Affects patient responsibility
Copay Amount	Insurance portal / phone call	Collect at time of service
Prior Auth Required?	Insurance portal / phone call	Get auth number if yes
Reference Number	Call to insurance company	Proof of verification

■■ **IMPORTANT: If a patient's insurance cannot be verified or is inactive, talk to them BEFORE the visit. Offer a payment plan or self-pay discount so there are no surprises later.**