**Business Name
TIN-
NPI-**

**Workers Comp & Auto Verification**

|  |  |
| --- | --- |
| **Patient Name:Liable Entity Name:**  | **Date of Birth:SSN: \_\_\_\_\_\_\_\_\_\_\_Date of Injury:**  |
| **Adjustor Name:****Phone-\_\_\_\_\_\_\_\_\_\_****Fax-\_\_\_\_\_\_\_\_\_\_\_\_Email\_\_\_\_\_\_\_\_\_\_\_\_** | **State of Injury: Date of Surgery (IA):Expectation for claim processing:**  |
| **Claim #** | **Billing Address:** |
| **Open and Active: Y/N** | **Phone:**  |
| **Effective Date:** | **PRIMARY** or **SECONDARY** |

**Network:** IN or OUT

**Network:** IN or OUT

**Deductible:** Ind. / Fam. / **or** WAIVED

**# of visits allowed:** / **or** NO LIMIT

**Is there a visit limit? How many visits have been used this year? \_\_\_\_\_\_** **Any Chiro included?**

How are we sending claims to liable entity? Electronic- Fax- Mail: \_\_\_\_\_\_\_\_\_: PayerID or Fax #

Physician Referral or Order: YES or NO- If yes, who’s the PCP? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior Authorization: YES or NO- If yes, how is auth obtained? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTES: \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CALL REFERENCE#: REP NAME:

Employee Printed Name:

Employee Signature: Date: