NEW INSURANCE FORM

Today's Date: _____ **Completed by** ☐ **Patient** ☐ **Staff/Clinician Initials** _____ ☐ Verbal ☐ Email ☐ Portal

BELOW INFORMATION - To be completed by Responsible Party/Patient

List below *ALL* family members affected by this change of insurance that are seen at PRA!!

1. _____ **2.** _____
Patient first name last date of birth Patient first name last date of birth

3. _____ **4.** _____
Patient first name last date of birth Patient first name last date of birth

Effective Date of Policy: _____

Check ***ALL*** clinicians affected by this insurance change

☐ **Resis** ☐ **Woods** ☐ **Pucha** ☐ **Fabsik** ☐ **Bard** ☐ **McFaul** ☐ **Chang** ☐ **Va** ☐ **Mateo**
☐ **Nawaz** ☐ **Rhee** ☐ **Komarovsky** ☐ **Wallen** ☐ **Astleford** ☐ _____

☐ **Therapist(s) List Name(s):** _____

Do you want a call regarding new benefits? ☐ No ☐ Yes – What Phone Number? (_____) _____-_____

Patient Relation to the Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Policy Holder's Name: _____ **Policy Holder's D.O.B**: _____-_____-_____

Policy Holder SS# _____-____-_____ **Policy Holder Phone #: (_____) _____-_____**

Name of Insurance: _____ **ID#**_____ **Group #**: _____

Insurance Phone #: (____) ____-_____ **Policy Holder Place of Employment**: _____

Secondary Insurance? ☐ No ☐ Yes – Complete: 2nd Insurance Name: _____

ID #:_____ **Group #:**_____ **2nd Insurance Phone #: (____) ____-_____**

Policy Holder's Name for Secondary: _____ **Policy Holder's D.O.B**: ____-____-_____

Failure to complete ALL this information may result in insurance not being changed in our system timely, could result in services denied if precertification was not obtained prior to change of insurance and may result in full payment due by patient!

STAFF DOCUMENTATION ONLY BELOW

MD – Next Appointment _____ **MD** – Last Appointment _____

Benefit Specialist

- **Reviewed ALL accounts in BILLING?** ☐Yes ☐ No (other patient accounts who need benefits updated)
- **Date Benefits up-loaded into EMR/completed** _____ **Benefits done by**: _____
- **Date Benefit Specialist notified Biller**: _____ ☐ Email ☐ TEAMS ☐ To Do

  Required: ☐ Include in communication to biller if patient identified above that they want a call back regarding benefits
- **Billers emailed**: ☐ Susan ☐ Heather ☐ Jennifer ☐ Amy ☐ Brittany ☐ Other_____
- **Date Benefit Specialist notified therapist**: _____ ☐ Email ☐ Voicemail ☐ TEAMS ☐ To Do
- **Benefits Specialist – Accounts updated in all EMR** Date: _____

  ☐ Sticky Note ☐ Insurance Active / Old ☐ CoPay / Co-Insurance / Deductible ☐ Remove Old Notes!

Billers

Document the following on financial note in Insync.

- **Contact patient and document in EMR for any issues with new insurance**
  - Yes • No – no issues with benefits • Patient requested a call
- **For New Insurance – Any past DOS need to be rebilled?** • Yes • No • N/A
- **Documented calls, lapses issues in EMR** • Yes • None needed

Comments:

Staff Completing Form: _____ **DATE**: _____