

ATTENTION: Documents to Return ASAP



The following forms are to be completed in their entirety and returned to us via fax at 770-592-2092 as soon as you receive them.

These forms help us assist you in a more efficient and timely manner and allow us to verify benefits *in advance* so we can appropriately serve you on the day of your visit.

We have an outside source that verifies medical and prescription drug insurance benefits for us. It is a courtesy service we offer to our patients, and there is no cost to you for this service. We have provided two copies of the form entitled *Atlanta Center for Reproductive Medicine - Authorization for Verification of Insurance Benefits*. One copy is for you to complete and the other copy is for your spouse/partner to complete.

Please remember to sign and date each form where requested. Your signature gives us permission to verify your benefits and file any claims where appropriate.

If you have any questions regarding these forms, please feel free to call us at 770-928-2276, and we will be happy to answer them.

DOCUMENTS TO RETURN VIA FAX to 770-592-2092

Authorization For Verification of Insurance Benefits

Do not discard your originals once you fax them to us. We will get those originals from you when you come for your first visit.

**ATLANTA CENTER FOR REPRODUCTIVE MEDICINE
AUTHORIZATION FOR VERIFICATION OF INSURANCE BENEFITS
AND PREQUALIFICATION FOR OTHER PATIENT FINANCIAL SERVICES**

Note: A separate form must be completed for husband and wife, if applicable. * Social Security Number is requested in that most insurance companies identify covered persons by social security number.

Patient's Name _____ Date of Birth _____ Patient's Social Security No.* _____

Insured's Name _____ Date of Birth _____ Insured's Social Security No.* _____

Insured's Address _____ Home Phone Number _____

Patient's relationship to Insured: ___ Self ___ Spouse ___ Other _____

Complete the following, using your health insurance card.

Primary Insurance Company _____

Insurance Company Phone number listed on card for Benefits determination _____

ID No. _____ Group No. _____

Insured's Employer _____ Policy No. _____

Secondary Insurance Company

Insurance Company Phone number listed on card for Benefits determination _____

ID No. _____ Group No. _____

Insured's Employer _____ Policy No. _____

Complete the following, using your prescription benefits card, if you have one.

Primary Insurance Company

Insurance Company Phone number listed on card for Benefits determination _____

ID No. _____ Group No. _____ Policy No. _____

Other No. (Specify Type) _____ Insured's Employer _____

Secondary Insurance Company _____

Insurance Company Phone number listed on card for Benefits determination _____

ID No. _____ Group No. _____ Policy No. _____

Other No. (Specify Type) _____ Insured's Employer _____

I hereby give my permission for Atlanta Center for Reproductive Medicine (ACRM), OR third party company who it designates to obtain from my health insurance and prescription benefits companies full and complete health insurance and medication coverage information, including, but not limited to coverage related to infertility (**if applicable**). I give my permission to ACRM to forward the information provided above to the third party company for benefit verification purposes. I give my permission to the third party company to forward health insurance benefit and prescription benefit information obtained from my insurance companies to ACRM. A facsimile of this signed document shall stand as an original. I also hereby give my permission to ACRM, to forward certain medical information it deems necessary to an outside third party who is designates to determine my eligibility to participate in certain patient financial service programs that are made available through ACRM. These include, but are not limited to the Shared Risk Program and Family Fee Financing Program. Patients are in no way required to participate in these programs. I likewise give my permission to the third party company to forward to ACRM my prequalification status. The health insurance and medication benefits verification program and the financial services prequalification program is offered as a courtesy and without charge. Neither ACRM or the third party company performing the insurance verification of benefits and prequalification for patient financial service programs shall have any liability to any person with respect to assistance provided under the program, including if insurance or the reimbursement coverage is verified under the program, but coverage is later denied; or if the prequalification is preliminarily granted but subsequently not granted. Patients are encouraged to confirm all insurance or reimbursement coverage determinations made under the program directly with their insurance carrier or other reimbursement source.

Signature _____ Date _____

Revision Date 02/01/2005

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Insurance Company Phone number listed on card for Benefits determination _____

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ID No. _____ Group No. _____ Policy No. _____

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Signature _____ Date _____

