VERIFICATION OF BENEFITS (VOB)

Org Name: **Tax ID:** **Grp NPI:** **Prov NPI:**

1. PATIENT INFORMATION

Patient Name **DOB** **Insurance Effective Date**

Insurance Plan **Ins ID #** ☐ Primary ☐ Secondary ☐ Supplemental

Group # **Policy Holder** **Policy Holder DOB**

2. STATUS WITH INSURANCE

Is Organization ☐ In Network **Is there a benefit** ☐ Yes ☐ No

☐ Out of Network **Is there a benefit** ☐ Yes ☐ No

Are we able to file out of network? ☐ Yes ☐ No

3. BENEFITS

Are Hearing Tests Covered? ☐ Yes ☐ No **Are Hearing Aids covered?** ☐ Yes ☐ No

How often is the benefit available? **When was is last used?**

How many Hearing Aids are covered? ☐ 1 ☐ 2 **Is the benefit** ☐ Per calendar year ☐ Per contract year

What is the amount of benefit per aid? $ **Max $**

Deductible Amount $ **Amount Met?** **Amount due today $**

What is the member's Co-pay? $ **What is the member's Co-insurance?** (insurance pays / member pays) % / %

Insurance Plan Maximum allowed amount per contract? $

Are the any exclusions to the benefit? Please specify (Age restrictions, Illness)

4. ADDITIONAL INFORMATION REQUIRED TO FILE A CLAIM

Does the patient have these benefits?			Are any of these required?		Which codes are covered?	
Accessories	V5268	$	Audiogram	☐	V5241	dispensing fee, monaural
Batteries	V5266	$	Prior Authorization	☐	V5160	dispensing fee, binaural
Ear Molds	V5264	$	Letter of Necessity	☐	V5257	HA, digital, monaural, BTE
Ear Impressions	V5275	$	Pre-Certification	☐	V5261	HA, digital, binaural, BTE
Repairs	V5014	$	Prescription	☐		
Supplies	V5267	$	Physician Referral	☐		
Upgrade deluxe	S1001	$				

Are these included in maximum benefit?

5. Required for Follow Up

Claim Address

Ins Rep Name **Reference Number for call** **Time**

PCC Name **Date Verified**

Additional Notes: **If pre-auth is required, request transfer to pre-auth department.** **Driver's license verified:** Y N