

Chris Duffy  
903 Forsythe Lane  
Houston, Texas 77073

Bill for Initial Prenatal Visit? Y\_\_ N\_\_ Date of Initial Visit \_\_\_\_\_ Do Verification? Y\_\_ N\_\_

**Insurance Eligibility Verification Form**

DATE \_\_\_\_\_

\_\_\_\_\_  
**Client's Name**

\_\_\_\_\_  
**Birth Date**

\_\_\_\_\_  
**Due Date of Birth**

\_\_\_\_\_  
**Client's Address**

\_\_\_\_\_  
**Phone Number**

G\_\_ P\_\_ LMP \_\_\_\_\_

\_\_\_\_\_  
**Insurance Company**

\_\_\_\_\_  
**Phone Number**

\_\_\_\_\_  
*Claims Address*

\_\_\_\_\_  
*Rep Name*

\_\_\_\_\_  
*Time*

\_\_\_\_\_  
**ID or Policy Number**

\_\_\_\_\_  
**Group Number**

\_\_\_\_\_  
*Plan Name*

\_\_\_\_\_  
**Name of Insured**

\_\_\_\_\_  
*Insured's Date of Birth*

\_\_\_\_\_  
*Relationship to Client*

\_\_\_\_\_  
**Employer of Insured**

=====DO NOT WRITE BELOW THIS LINE=====

\_\_\_HMO \_\_\_PPO \_\_\_EPO \_\_\_QPOS \_\_\_POS \_\_\_Standard Medical \_\_\_Self Funded Plan

Birth Center Y\_\_ % N\_\_

Home Birth Y\_\_ % N\_\_

Midwife? Y\_\_ % N\_\_

\_\_\_\_\_  
\$ Deductible

\_\_\_\_\_  
COPAY

\_\_\_\_\_  
\$ of Deductible met

\_\_\_\_\_  
Out of Pocket

\_\_\_\_\_  
Effective Date

Ultrasounds? Y\_\_ N\_\_

Deductible carry over? \_\_\_\_\_

Global Billing + Initial \_\_\_ or Itemized Billing \_\_\_\_\_

Precert Necessary for Homebirth? Y\_\_ N\_\_ Precert # \_\_\_\_\_ Precert Phone# \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_