Client Request for Verification of Benefits

Email to: tony@integritybillinggroup.com
(Or) Fax to: 414-375-2048

$25 Fee

☐ Cash ☐ Check #_____ (payable to Integrity Billing Group) ☐ Credit Card – an electronic invoice will be sent to you via Square

Client Information

Name: _____
Last, First

Address: _____
Street City State Zip

Phone: _____

Email: _____

Date of Birth: _____ Marital Status: _____

Estimated Due Date: _____ Is this your first pregnancy? ☐ Yes ☐ No

Previous C-Section? ☐ Yes ☐ No

Primary Insurance Information

Primary Insurance Company: _____

Plan Name: _____ Effective Date: _____

Insurance Phone #: _____

Subscriber's Name: _____
Last, First

Subscriber's ID #: _____ Group #: _____

Subscriber's Employer: _____

Subscriber's Date of Birth: _____ Patient Relationship to Subscriber: _____

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Please include a clear photo of BOTH the front AND back of your insurance card.

Secondary Insurance (if applicable)

Secondary Insurance Company:

Plan Name: Effective Date:

Insurance Phone #:

Subscriber's Name:
Last, First

Subscriber's ID #: Group #:

Subscriber's Employer:

Subscriber's Date of Birth: Client Relationship to Subscriber:

I certify that the information on this form is correct to the best of my knowledge. By signing this form, I authorize Integrity Billing Group to verify my insurance benefits. I hereby authorize my insurance company to make payment directly to my provider should claims be filed. I give authorization to my provider to release any information necessary to process my benefits or insurance claims. In some cases insurance claims may deny and require an appeal process. In this circumstance, I authorize Integrity Billing Group to pursue appeals on my behalf. I understand this will be at the discretion of Integrity Billing Group. I also understand that it may be necessary for Integrity Billing Group to contact me via email or by telephone if appeals are pursued. I understand the final outcome for my insurance benefits level and the processing of my claims is under the discretion of the insurance company. I will not hold Integrity Billing Group or my midwife/birth center responsible for the information reported on this verification or the manner in which my claims process.

Signed: Date:
Print Name to Sign Electonically