INSURANCE VERIFICATION FORM

PATIENT NAME:		**DOB:**	
INSURANCE:		**INSURANCE ID #:**	
NPI ASC:	1922193515	**TAX ID ASC:**	23-3056394
NPI HNA:	1477648863	**TAX ID HNA:**	23-1877511
DR. HOUSER NPI	1811979958		

CPT	**PROCEDURE**	**ICD 10 (OD)**	**ICD 10 (OS)**
76519	A-SCAN	H25.11	H25.12
66984	CATARACT	H25.11	H25.12
66821	YAG CAP	H26.491	H26.492
66991- Normal 66989- Complex	ISTENT WITH CATARACT SURGERY	H40.1111 MILD H40.1112 MODERATE	H40.1121 MILD H40.1122 MODERATE
66761	YAG PI	H40.031	H40.032
65855	ALTP LASER	H40.111?	H40.112?
11200	SKIN TAG	D23.111 UPPER D23.112 LOWER	D23.121 UPPER D23.122 LOWER
11440	LESION	D23.11	D23.12
68761	PUNCTAL PLUG	H04.121	H04.122
		H04.123 **(OU)**	
10060	I&D CHALAZION	H00.19 (unspecified eye/lid)	
67800 (single) 67801(multiple same lid) 67805(multiple different lids)	EXCISION CHALAZION	H00.19 (unspecified eye/lid)	

Is the MVASC facility in network?	YES	NO	Copay:
Does the patient have benefits for the above procedure?	YES	NO	
Does the patient need prior authorization?	YES	NO	
If yes, authorization number:			
Reference number for call:			
Person spoke with:			
Date/Time of call:			
Staff member completing this insurance verification:			