MVA - Insurance Coverage Verification Form

Date of call: _____ Time:_____ Person making this call:_____

MVA INSURANCE INFORMATION:

FIRST DOS _____ / **PROVIDER**_____

___New Patient ___Existing Patient

Patient Name: _____

Gender associated with: **Male / Female / Other** **Date of Birth:** _____

Patient Address: _____ **Phone #:** _____

MVA Insurance (must be *patient's MVA*):_____ PIP Claim#_____

Claim Address:_____

Claim Adjuster:_____ Phone #:_____

Can claims be faxed Y / N? If so, FAX #:_____

Date of Injury/Accident:_____ State Accident Occurred In(OR, WA, etc.): _____

***Is PIP Claim open **Y / N**? Is coverage based on Oregon limits **Y / N**? (1 year from DOI or $15,000 max)*

For LMT – PCP referral required Y/N? If yes, what type of PCP – MD / ND / DC (chiro)?

MVA PATIENT RESPONSIBILITY ACKNOWLEDGEMENT & ASSIGNMENT AUTHORIZATION:

1) I understand that any and all natural pharmacy ("medicinary") items, food, and other products obtained and / or purchased from the treating provider/facility are my full financial responsibility and will not be billed to the MVA insurance carrier.
2) I understand that I am financially responsible for any and all services rendered to me by the treating provider/facility that are not paid by the MVA insurance carrier if: **A)** my case/claim goes to Independent Medical Evaluation (IME) or review and is determined that services provided to me are not MVA related or do not qualify for MVA reimbursement; **B)** my Personal Injury Protection claim (PIP) is closed, terminated, or expired, and/or; **C)** any of the information I have provided is incorrect or falsified and has resulted in the treating provider's/facility's inability to directly bill for and/or receive reimbursement from the MVA insurance carrier.
3) I understand that non-compliance with payment terms may immediately result in my forfeiture of any and all insurance billing options extended to me by the treating provider/facility.
4) I authorize release of information in my medical history to the MVA insurance carrier and assign all benefits for unpaid services to the treating provider/facility. Assignment will remain in effect until revoked by me in writing.

Patient Signature: _____ **Date:**_____