Insurance Information Verification

Please complete all sections that apply to you

PATIENT INFORMATION

LAST NAME | FIRST NAME | MIDDLE INITIAL

DATE OF BIRTH | SEX | SOCIAL SECURITY NUMBER (LAST 4) | PHONE

MAILING ADDRESS | CITY | STATE / ZIP

EMAIL ADDRESS | PREFERRED CONTACT METHOD

Primary Insurance

INSURANCE COMPANY NAME | PLAN TYPE | EFFECTIVE DATE

MEMBER ID NUMBER | GROUP NUMBER | PLAN/POLICY NUMBER

MEMBER SERVICES PHONE | PRE-AUTHORIZATION PHONE | PHARMACY/MEDICAL BENEFIT?

SUBSCRIBER NAME (IF NOT PATIENT) | SUBSCRIBER DOB | RELATIONSHIP TO PATIENT

SUBSCRIBER EMPLOYER (IF APPLICABLE) | SUBSCRIBER PHONE

Secondary Insurance (if applicable)

INSURANCE COMPANY NAME | PLAN TYPE | EFFECTIVE DATE

MEMBER ID NUMBER | GROUP NUMBER | PLAN/POLICY NUMBER

SUBSCRIBER NAME (IF NOT PATIENT) | **SUBSCRIBER DOB** | **RELATIONSHIP TO PATIENT**

Medicare or Medicaid

MEDICARE ID (HICN/MBI) | **MEDICARE EFFECTIVE DATE** | **PART B EFFECTIVE DATE** | **PART D PLAN**

MEDICAID ID NUMBER | **STATE** | **MEDICAID EFFECTIVE DATE** | **PLAN NAME**

Pharmacy Benefit (for self-administered & specialty pharmacy)

PHARMACY BENEFIT MANAGER (PBM) | **RXBIN** | **RXPCN** | **RXGROUP**

MEMBER SERVICES PHONE | **SPECIALTY PHARMACY USED (IF KNOWN)**

Authorization & Assignment of Benefits

I authorize Ascribe Infusion Therapy to verify my insurance coverage, obtain prior authorization for prescribed therapies, and submit claims to my insurance plan(s) on my behalf. I assign all medical benefits to which I am entitled to Ascribe Infusion Therapy as direct payment for services rendered. I understand that I am responsible for any portion of charges not covered by my insurance, including copayments, coinsurance, deductibles, and non-covered services. I agree to notify Ascribe promptly of any changes to my insurance coverage.

- ☐ I have provided photocopies of all insurance cards (front and back) and a valid photo ID.
- ☐ I will provide an estimate of out-of-pocket cost prior to my first infusion. I understand actual costs may vary based on what my insurance ultimately approves.

PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE SIGNATURE | **PRINTED NAME** | **RELATIONSHIP TO PATIENT (IF NOT SELF)** | **DATE**

Form code: ASC-INS-001 · Ascribe will verify benefits within 1–2 business days and contact you with an estimate before your first infusion.