Durable Medical Equipment Insurance Verification Form

Patient Name

Date of Birth

Patient Phone

Patient ID #

Address

City, State, ZIP

Physician Name

Physician NPI #

Insurance Company

Insurance Phone #

Policy #

Group #

Subscriber Name

Subscriber Date of Birth

Relationship to Patient

DME Item(s) Requested

Diagnosis/ICD-10 Code(s)

Insurance Representative Name

Date Verified

Authorization/Reference #

Notes