



## Eligibility Insurance Form

Do you know your benefits?

**Please call your insurance company to complete this form correctly.**

This form is to help you/us better understand your benefits and to help assist in the future care of your child/children. If we know in advance that preventative visits and immunizations are not a covered benefit, we may be able to administer immunizations here at the office through the Texas Vaccine for Children program. We ask of you to call your insurance company and ask them the following questions.

**\*\* Please bring the completed form back by the patient's next visit. \*\***

**\*\*\* NEWBORNS: Newborns need to be added to the policy BEFORE one month of age. We ask that you bring this form back completed by the baby's one-month appointment. \*\*\***

Name of Patient: \_\_\_\_\_

Name of Insurance? \_\_\_\_\_

Phone Number? \_\_\_\_\_ Representative's Name? \_\_\_\_\_

Has Primary Care Physician been chosen (if applicable)? \_\_\_\_\_

Copay? \_\_\_\_\_ Deductible? \_\_\_\_\_

\*\*\* If there is a deductible, has it been met? \_\_\_\_\_ How much? \_\_\_\_\_

Are well child visits covered? \_\_\_\_\_ Age limit? \_\_\_\_\_

Is there a maximum \$ amount per year? \_\_\_\_\_

If yes, Does the maximum include vaccines? \_\_\_\_\_

Are vaccines covered? \_\_\_\_\_

Prevnar (90669)? \_\_\_\_\_ Hepatitis A (90633)? \_\_\_\_\_

Proquad (90710) \_\_\_\_\_ Rotateq (90680) \_\_\_\_\_ Adacel (90715) \_\_\_\_\_

Gardasil (90649) \_\_\_\_\_ Influenza (90657/90658)? \_\_\_\_\_

Pres.-Free Influenza (90655/90656)? \_\_\_\_\_

Flumist (90660/for children 5yrs & up/without history of asthma)? \_\_\_\_\_

Hearing Screen (92551)? \_\_\_\_\_ Vision Screen (99173)? \_\_\_\_\_

Is there a primary Lab (CPL/Lab One/Quest/Seton)? \_\_\_\_\_

If you wish to waive this form please check the box below and we will bill to your insurance accordingly and any uncovered costs incurred will be the responsibility of the patient.

I do not wish to complete this form.

I am aware of my benefits and insurance coverage and understand that any unpaid or denied portions of my claims will be my responsibility.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

I would like a copy of this statement.