Required Benefits Form for Insured Patients

Patient Name:_____

Insurance Carrier:_____ **Member ID**_____

Aurora Family Health is happy to bill your insurance for your care; however, **it is the patient's responsibility** to be aware of her/his coverage and co-pay, as well as any deductible and out-of-pocket maximums specific to your individual plan.

Please follow these steps to get the most accurate information on your benefits and eligibility.

First, call the number listed on your insurance card for customer service. You may be prompted to say or enter a number based on what information you are looking for. You want information on **coverage and benefits.**

Fill out the following questionnaire based on information given by your live representative:

1. When did my coverage begin and when is it valid through?
   Beginning date_____ Ending date_____

2. Is Susie Corcoran, FNP, CNM, an in-network provider with my insurance?

   Yes____ No____

3. What are the benefits for the following services? (applicable to the care you are seeking)

Global maternity: % covered by insurance_____; % co-insurance_____; copay_____

Office visit, illness: % covered by insurance_____; % co-insurance_____; copay_____

Preventative care (annual exams, well-child visits)

% covered by insurance_____; % co-insurance_____; copay_____

4. What is my deductible? $_____ How much, if any, has been met?_____
   Is maternity care subject to deductible? Yes____ No____
5. What is my out-of-pocket maximum? $ _____

6. Name of representative you spoke with: _____