MEDICAL / HEALTH INSURANCE VERIFICATION FORM

Request Date: Verification As-Of Date: Governing State: [STATE]

1. Parties

Requesting Party: [REQUESTING PARTY] Contact: [REQUESTING PARTY CONTACT PHONE EMAIL ADDRESS]

Responding Party: [RESPONDING PARTY] Contact: [RESPONDING PARTY CONTACT]

This verification is being requested by [REQUESTING PARTY] as of . Please complete all applicable fields and return to the contact above.

2. Subject of Verification

- **Full legal name:** [SUBJECT NAME]
- **Date of birth:**
- **Address:** [SUBJECT S CURRENT ADDRESS]

Privacy notice: Full Social Security Numbers must not be printed or displayed on this form. Only the last four digits are collected, consistent with California Civil Code §1798.85 and equivalent state-law restrictions on SSN disclosure on documents transmitted by fax, email, or mail.

3. Medical / Health Insurance Coverage

- **Carrier:** [INSURANCE CARRIER NAME]
- **Member ID:** [POLICY MEMBER ID NUMBER]
- **Plan type:** Ppo
- **Coverage effective:**
- **Coverage expiration / renewal:**
- **Individual deductible:** $0.00 (met YTD: $0.00)
- **Out-of-pocket maximum (individual):** $0.00
- **Requesting provider in-network:** Yes

4. Federal Compliance Overlays

HIPAA — Authorization to Release Protected Health Information

Protected Health Information (PHI) is governed by the HIPAA Privacy Rule, 45 C.F.R. Part 164. The subject named above authorizes [RESPONDING PARTY] to release the information requested on this form to [REQUESTING PARTY] for the purpose of verifying insurance coverage and benefits.

- **Expiration of authorization:** (45 C.F.R. §164.508(c)(1)(v)).
- **Right to revoke:** The subject may revoke this authorization at any time by submitting a written revocation to the responding party. Revocation is not effective to the extent the responding party has already acted in reliance on the authorization.
- **Conditioning prohibited:** Treatment, payment, enrollment, or eligibility for benefits is not conditioned on the signing of this authorization, except as permitted under 45 C.F.R. §164.508(b)(4).
- **Redisclosure notice:** Information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA.

If this verification is a routine disclosure by a treating provider to the subject's health plan for payment or healthcare operations (TPO), it falls within 45 C.F.R. §164.506 and no separate authorization is required.

HIPAA — Minimum Necessary

This form is designed to collect only the minimum PHI necessary to verify benefits, consistent with 45 C.F.R. §164.502(b). Diagnosis codes, treatment histories, and other PHI beyond what is required for verification shall not be disclosed on or in connection with this form.

No Surprises Act

Pursuant to the No Surprises Act (Pub. L. 116-260, Div. BB; 45 C.F.R. Part 149), this verification captures in-network provider status and prior-authorization requirements to support the requesting provider's obligation to furnish good-faith cost estimates and advanced explanations of benefits to the subject.

Mental Health Parity

Mental health and substance use disorder benefits must be at parity with medical and surgical benefits under the Mental Health Parity and Addiction Equity Act (29 U.S.C. §1185a) and the Consolidated Appropriations Act, 2021. The responding party shall confirm that deductibles, copays, coinsurance, visit limits, and prior-authorization standards for mental health benefits are no more restrictive than those applied to medical/surgical benefits.

5. State-Specific Overlays

6. Certification / Attestation

The undersigned authorized representative of **[RESPONDING PARTY]** certifies that the information provided on this form is true, accurate, and complete, to the best of the representative's knowledge, **as of **, based on records maintained in the ordinary course of business. False certification may constitute fraud under federal wire-fraud (18 U.S.C. §1343), mail-fraud (18 U.S.C. §1341), or state fraud statutes.

Disclaimer. The information on this form is current as of the verification date and is subject to change without notice. [RESPONDING PARTY] makes no warranty, express or implied, regarding the accuracy of information beyond the verification date. Coverage, loan status, tenancy terms, and employment status may change.

7. Subject Authorization

By signing below, I, **[SUBJECT NAME]**, authorize [RESPONDING PARTY] to release the information requested on this form to [REQUESTING PARTY] for the purpose stated above. I have had the opportunity to review this form and the authorization provisions in Section 4.

Signatures

Subject / Authorizing Party

_____ PRINTED NAME

_____ SIGNATURE

_____ DATE

Responding Party Representative

_____ PRINTED NAME

_____ SIGNATURE

_____ DATE