Spokane Midwives

Tax ID: 91-2015725

The information obtained for this form does not guarantee your coverage. Spokane Midwives is not responsible for any deviation from the insurance coverage listed below. Please consult your plan details provided by your insurance company to clarify and verify plan limitations.

Verification of Benefits (VOB): Primary Insurance (please call your insurance to fill out this form)

**(Does not apply to Apple Health or WA State Managed Care Programs)**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Member #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Call Reference #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Tax ID in your system? □Yes □No Is this provider contracted with this plan? □Yes □No

My plan pays at the following rates: □ In-Network Rates □ Out-of-Network Rates

Deductible: $\_\_\_\_\_\_\_\_\_ Out-of-Pocket Maximum: $\_\_\_\_\_\_\_\_\_\_ Included in Deductible?: □Yes □No

Coinsurance: insurance pays \_\_\_\_\_\_\_\_\_% of allowable, member pays remaining \_\_\_\_\_\_\_\_\_%

Deductable waived for prenatal visits?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-pay?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are **C**ertified **P**racticum **M**idwives Covered? □Yes □No Are **L**icensed **M**idwives Covered? □Yes □No

Is a pre-auth required for outpatient maternity care? □Yes □No (if needed give cpt 59400)

Birth Center contracted with plan? □Yes □No Birth Center birth covered under plan? □Yes □No

\_\_\_\_\_\_\_\_\_% covered with the facility, member pays remaining \_\_\_\_\_\_\_\_\_%

Is a Homebirth covered with this plan? □Yes □No

Baby covered under Mom? □Yes □No How many days? \_\_\_\_\_ Baby deductible? □Yes □No

If yes, does deductible apply during the first 30 days of coverage? □Yes □No

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have secondary insurance coverage? □Yes □No