

# PROGRESSIVE CARE NETWORK INSURANCE VERIFICATION

Requesting Vendor: \_\_\_\_\_ Phone #: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Fax #: \_\_\_\_\_

Request Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Birth date: \_\_\_\_\_

Insurance Type:                    **Commercial**                    **Medicare Program**                    **Medicaid Program**

Policy Holder: \_\_\_\_\_ SSN: \_\_\_\_\_

Birth date: \_\_\_\_\_ Patient Relationship to Insured: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Employer: \_\_\_\_\_

Effective Date of Policy: \_\_\_\_\_ Medicare Supplement:                    Y                    N

Coverage Amount:                    % \_\_\_\_\_ Major Medical Coverage:                    Y                    N

Deductible: \_\_\_\_\_ Has Deductible Been Met:                    Y                    N

Out Of Pocket Max: \_\_\_\_\_ After \_\_\_\_\_ Amt: \_\_\_\_\_ Total: \_\_\_\_\_

Lifetime Max: \_\_\_\_\_ Pre-existing Condition Clause:                    Y                    N

Coverage Under Drug Plan:                    Y                    N                    Policy Covers Skilled Nursing:                    Y                    N

**Pre-Certification Is Required:**                    Phone Number: **317-596-2805**

**Case Manager Name and Phone Number: To be provided by PCN as needed**

Mailing Address for Claims:                    **Progressive Care Network**  
**7202 E. 87th Street, Suite 103**  
**Indianapolis, IN 46256**  
 Fax Number for Claims:                    **317-596-3711**

**Please fax claims with a cover letter listing Patient Name/s and Date/s of Service.**  
**Please include a return number to fax claim receipt confirmation to.**  
**If claims have been faxed, please do not mail them.**