Musculoskeletal Institute of Louisiana

Orthopedic Specialists of Louisiana • Pain Care Consultants

Insurance Verification Form

Date _____

Patient Name _____ DOB _____

Ordering Physician _____ Person # _____

☐ CT ☐ MRI _____

Diagnosis _____

Attorney ☐ YES ☐ NO

Name _____ Phone #_____

Work Comp ☐ YES ☐ NO

Work Comp Carrier _____ Date of Injury _____

The above information is correct to the best of my knowledge, and I consent to such diagnostic procedure deemed necessary by my physician for my treatment.

I understand that the staff will contact my insurance company to verify coverage and obtain an authorization if required. This does NOT confirm eligibility for coverage or payment, nor does it assume coverage under my benefit plan. I am responsible for any charges incurred for my MRI/CT that my insurance company does not cover. Musculoskeletal Institute of Louisiana will file my insurance when appropriate, but I will ultimately be responsible for all balances.

_____ _____

Patient Signature Date