



# LARSEN BILLING SERVICE

## Verification of Benefits (VOB)

Primary Insurance     Secondary Insurance  
**Midwife/Credentials** \_\_\_\_\_ Billing Rep. \_\_\_\_\_  
**Birth Center/Business Name** \_\_\_\_\_ VOB Rep. \_\_\_\_\_  
**Member** \_\_\_\_\_ **ID #:** \_\_\_\_\_ Insurance Rep. \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Provider's tax ID in your system?  Yes  No  
 Claims Mailing Address \_\_\_\_\_ Electronic Payer ID # \_\_\_\_\_  
 Phone \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ Plan Effective Date \_\_\_\_\_

Is this provider contracted with this plan?  Yes  No Notes: \_\_\_\_\_

We expect the provider to be covered at the following rates for this member's plan:  Out-of-Network Rates  In-Network Rates  Pending

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

**Out-of-Network Benefits:** *(most midwives are covered at this rate, unless contracted with the specific insurance company)*

% covered with out-of-network provider \_\_\_\_\_%, Member Pays \_\_\_\_\_%, Deductible \$ \_\_\_\_\_, Deductible Met \$ \_\_\_\_\_

**In-Network Benefits:** *(for reference only, unless midwife is specifically contracted with this insurance company or we are able to obtain an exception)*

% covered with in-network provider \_\_\_\_\_%, Member Pays \_\_\_\_\_%, Deductible \$ \_\_\_\_\_, Deductible Met \$ \_\_\_\_\_

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

Which Midwives are covered?  Certified Professional  Registered Midwife  Licensed Midwife  Certified Nurse Midwife

Notes: \_\_\_\_\_ -- Is pregnancy a pre-existing condition?  Yes  No

In / Out -of-network reimbursement will be sent to:  Provider  Member \_\_\_\_\_

Is a Homebirth excluded? \_\_\_\_\_ Is a Birth Center excluded? \_\_\_\_\_

**Birth Center Benefits:** *(if applicable)* Is this Birth Center contracted with this plan?  Yes  No Notes: \_\_\_\_\_

% covered with out-of-network facility \_\_\_\_\_%, % covered with in-network facility \_\_\_\_\_%, Notes: \_\_\_\_\_

Baby covered under mom?  Yes  No How many days? \_\_\_\_\_ Does baby have own deductible? \_\_\_\_\_

**Authorization / Referral** - is an authorization or referral required for outpatient maternity care?  Yes  No

Name of Insurance Rep. \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ Authorization obtained?  Yes  No

Ref. # while pending: \_\_\_\_\_ Approved auth. # \_\_\_\_\_ Date Obtained: \_\_\_\_\_

**In-Network Exception** - is it possible on this plan?  Yes  No --Who should set this up?  Provider  Member

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

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

Rep spoken to: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ Ref. # while pending \_\_\_\_\_

Except. obtained?  Yes  No Approved Except. # \_\_\_\_\_ Date range approved \_\_\_\_\_

Codes auth'd (circle): for mom: 59400, 99204 (or 99205), 99214 (or 99215), 99354, 99355, 99349, 0724-facility for baby: 99461, 99213, 99348, 99464, S3620, 0724-facility

(Maternity Benefits CPT Code = 59400 / Diagnosis Code V22.2 for mom)