

**PATIENT INFORMATION**

**TODAY'S DATE** \_\_\_\_\_

NAME (Last, First, Middle) SSN# BIRTHDATE AGE M F

ADDRESS CITY STATE/ZIP

EMAIL ADDRESS HOME PHONE CELL PHONE

EMPLOYER OCCUPATION REFERRED BY

ADDRESS EMPLOYER PHONE MAIDEN NAME

**SPOUSE/NEXT OF KIN INFORMATION**

NAME (Last, First, Middle) SSN# BIRTHDATE AGE M F

ADDRESS DAYTIME PHONE RELATIONSHIP TO PATIENT

**PRIMARY INSURANCE**

NAME OF INSURANCE COMPANY POLICY NUMBER

NAME OF INSURED GROUP NUMBER

CLAIMS MAILING ADDRESS INSURED BIRTHDATE

CUSTOMER SERVICE NUMBER COPAY \$

**SECONDARY INSURANCE**

NAME OF INSURANCE COMPANY POLICY NUMBER

NAME OF INSURED GROUP NUMBER

CLAIMS MAILING ADDRESS INSURED BIRTHDATE

## ***FINANCIAL POLICY***

Please take time to review our financial policy so that we may address any questions **prior** to receiving services. The list of questions for your insurance company must be completed and brought with you upon your initial appointment. If you are an established patient and have not completed this form please ask the receptionist or contact Monica for a copy.

### **PAYMENT AT THE TIME OF SERVICE**

Mid-Iowa Fertility requires payment in full at the time of service. If you **do** have insurance benefits for infertility treatment you will need to speak Monica prior to any form of fertility treatment. We will assume that you have **no** fertility benefit unless you notify us otherwise.

**Patient initials** \_\_\_\_\_

### **FLEX SPENDING**

We understand that many of our patients have the opportunity to use their Flex Spending account for services not covered by their health plan. If your Flex Spending requires a denial from your insurance carrier please let us know. We will be glad to submit a claim to the insurance carrier with a notification that you have paid the claim in full.

**Patient initials** \_\_\_\_\_

### **PHARMACY SERVICES**

Many times our physicians may recommend that you move forward in using injectable fertility medications. It is the patients' responsibility to know if these medications are covered under your insurance plan. You will need to check with your insurance company or prescription drug card coverage to determine if prior approval or mail order is required.

**Patient initials** \_\_\_\_\_

### **ATTENTION COVENTRY HEALTHCARE AND FIRST HEALTH SUBSCRIBERS**

Mid-Iowa Fertility does not participate with Coventry Healthcare or First Health Direct. You will be required to pay for your services at the time of service.

**Patient initials** \_\_\_\_\_

### **ATTENTION LABCORP MEMBERS**

If you find the LabCorp or LABONE logo on your insurance card this means that **you** must notify our laboratory staff each time prior to having blood work drawn. Your blood work can be sent to one of these approved laboratories for the highest level of benefit.

**Patient initials** \_\_\_\_\_

### **WHEN YOUR PLAN COVERS TESTING ONLY**

Many insurance carriers offer benefits for testing only, meaning once treatment begins they will no longer cover services. Again, we require payment at the time of service.

**Patient initials** \_\_\_\_\_

CONSENT TO RELEASE INFORMATION

**Mid-Iowa  
FERTILITY, P.C.**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I, the undersigned, hereby authorize Mid-Iowa Fertility, P.C. to release medical information to the following:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Please list in order of preference **only** the numbers where you wish to phoned or we may leave a message.

#1 \_\_\_\_\_ this is my \_\_\_\_\_ number.

#2 \_\_\_\_\_ this is my \_\_\_\_\_ number.

#3 \_\_\_\_\_ this is my \_\_\_\_\_ number.

Our Administrative Staff including the Financial Specialist uses email to correspond to insurance and billing questions. Please clearly print your email address so we may respond to your inquiries.

\_\_\_\_\_ @ \_\_\_\_\_ .com

I authorize Mid-Iowa Fertility to release the insurance carrier(s) the information I have provided in order to facilitate claim payment. I permit a copy of this authorization to be used in place of the original signature and request payment of claims to Mid-Iowa Fertility. I understand I am responsible for all services received regardless of insurance payment or denial.

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**PATIENT SIGNATURE OR LEGAL GUARDIAN**

**DATE**

**PLEASE CONTACT YOUR INSURANCE COMPANY PRIOR TO YOUR APPOINTMENT TO RECEIVE A QUOTE OF BENEFITS. BRING THIS COMPLETED FORM ALONG WITH COMPLETED PATIENT REGISTRATION FORMS TO YOUR INITIAL APPOINTMENT.**

### **Questions for Your Insurance Company**

Today's date \_\_\_\_\_ Insurance Company \_\_\_\_\_

Insurance Company contact \_\_\_\_\_

What are my fertility benefits?

What is excluded?

Does my plan cover fertility testing?

Does my policy cover fertility treatment procedures such as insemination (CPT code #58322) or in vitro fertilization (CPT code #58970 & 58974)?

If I use fertility medications such as self-administered injectables medications would they be covered under my prescription drug card plan or my health plan? If from my health plan does this mean I pay upfront at the pharmacy and then be reimbursed from the insurance company?

Fertility self injectables such as; Follistim, Ovidrel, Repronex or Lupron are normally considered specialty drugs. Do I need to use a mail order for these?

If I move forward with treatment all services will take place in an office setting, what services require prior approval?

Does my plan have a fertility dollar maximum benefit or is it a number of attempts?

Are donor sperm and/or egg options covered? How about coverage to freeze sperm or embryos?

Do I have benefits for genetic testing? Codes #83894, #83900, #83901, #83912, #88230, #88262 and #88291 will be billed.

**With this completed form our financial department can assist you with your estimated out of pocket for proposed treatment once we have a quote of benefits from your insurance company. Be sure to save a copy of this form for yourself!**

You may contact Monica, our Financial Coordinator at (515) 222-3060 or email her [financial@midiowafertility.com](mailto:financial@midiowafertility.com)