BENEFIT FAX INQUIRY

Verification of Member Eligibility and Benefit Verification
Including member out of pocket

TO: PARAMOUNT – PROVIDER INQUIRY

FAX: (419) 887-2018

From: _____________________ Phone: __________________ Fax: __________________

Provider Name: ___________________________ Paramount Provider #: ____________

Please include applicable HCPCS Code(s) for DME, Orthotics, Prosthetics, and Pharmacy

Member _______________________ ID# _______________________________________

Date of Service _______________ Services to be provided ______________________

Provider Comments: ______________________________________________________

Paramount Response:

Member Effective Date: __________________ Group Renewal Date: ________________

Deductible: ___________ Coinsurance: ___________ Copay: __________________

Maximum out of Pocket Maximum: ___________ Amount Used: ______________

Product Line of Policy: _____________________ Self Funded (yes/no): __________

Prior Authorization Required (yes/no): _________ Pre-existing clause (yes/no): _______

Member _______________________ ID# _______________________________________

Date of Service _______________ Services to be provided ______________________

Provider Comments: ______________________________________________________

Paramount Response:

Member Effective Date: __________________ Group Renewal Date: ________________

Deductible: ___________ Coinsurance: ___________ Copay: __________________

Maximum out of Pocket Maximum: ___________ Amount Used: ______________

Product Line of Policy: _____________________ Self Funded (yes/no): __________

Prior Authorization Required (yes/no): _________ Pre-existing clause (yes/no): _______

Member _______________________ ID# _______________________________________

Date of Service _______________ Services to be provided ______________________

Provider Comments: ______________________________________________________

Paramount Response:

Member Effective Date: __________________ Group Renewal Date: ________________

Deductible: ___________ Coinsurance: ___________ Copay: __________________

Maximum out of Pocket Maximum: ___________ Amount Used: ______________

Product Line of Policy: _____________________ Self Funded (yes/no): __________

Prior Authorization Required (yes/no): _________ Pre-existing clause (yes/no): _______