FAMILY FERTILITY CENTER **www.familyfertility.com**
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PHARMACY BENEFIT PRE-VERIFICATION FORM

Family Fertility Center works with certain specialty drug pharmacies that offer complimentary insurance pre-verification of your fertility medication coverage so that you can maximize prescription benefits available to you. All specialty pharmacies are HIPAA compliant and any personal information provided to them will be kept strictly confidential. **If you would like a preliminary investigation of your prescription drug benefits, please complete and sign this form.**

First Name:_____ MI ____ Last Name: _____
Home Address: _____
City: _____ State: _____ Zip: _____ SSN: _____
Date of Birth: _____Home Phone #: _____ Cell Phone #:_____
Email: _____ Cycle Type: _____
Spouse's Name: _____Spouse Date of Birth: _____
Spouse SSN:_____Spouse Date of Birth:_____Phone #:_____

Please include a copy of all medical & prescription insurance cards – front & back.

Primary Medical Insurance Coverage

Plan Name: _____ Employer: _____
ID#: _____Group/Policy#:_____ Phone #:_____
BIN#:_____ PCN#:_____Policy Holder: _____

Primary Prescription Drug Insurance Coverage

Plan Name: _____ Employer: _____
ID#: _____Group/Policy#:_____ Phone #:_____
BIN#:_____ PCN#:_____Policy Holder: _____

Secondary Medical Insurance Coverage

Plan Name: _____ Employer: _____
ID#: _____Group/Policy#:_____ Phone #:_____
BIN#:_____ PCN#:_____Policy Holder: _____

Secondary Prescription Drug Insurance Coverage

Plan Name: _____ Employer: _____
ID#: _____Group/Policy#:_____ Phone #:_____
BIN#:_____ PCN#:_____Policy Holder: _____

Patient Signature: _____ Date: _____