



LARSEN BILLING SERVICE

Send form to LBS rep: Vanessa Romero
Fax - (630)206-1020

1302 8th Street Court Hampton, IL 61256
E-mail - vanessa.romero@larsenbilling.com

Toll-free phone: (866) 476-0565

Verification of Benefits (VOB) Transitions Midwifery Services, LLC Brandy Brandfass, LM, RN

(A \$15 fee per member applies when LBS calls for benefits and/or exceptions. Please do not send checks to LBS. LBS will bill your midwife for this fee – your midwife may send checks from members to LBS at the time that they pay their invoice. Thank you!)

Insurance Company: _____

Instructions from midwife/member to LBS regarding this VOB: _____

This VOB is for (member's name): _____ (Client reg. form must accompany this VOB)

Name of person completing this form: _____ LBS rep Member Other

Out-of-Network Insurance Benefits Phone# called to obtain benefits: _____

Name of insurance rep spoken to _____ Date _____ Time _____

Does this plan have out-of-network maternity benefits? yes no (If no, exception **must** be obtained or claims cannot be billed.)

Eligibility date: _____ Out-of-net deductible: _____ Amount of deductible left to meet: _____

What % of maternity benefits (code 59400) will be paid for an out-of-network provider? _____ (The remaining _____ % is patient responsibility.) Is a Licensed Midwife covered by this plan? _____

Is baby covered under mom? yes no If so, how long? _____ If not, when must baby be added to plan? _____ Insurance reimbursement will be sent to: provider member

Is pregnancy a pre-existing condition? (Can only apply to individual plans.) yes no _____

Is a referral or authorization for **outpatient** maternity care or newborn care required? (Typically, auths are only required for inpatient services and therefore do not apply to us.) yes no If yes, phone# to call for auth: _____

If auth required, fill out auth box* below. Comments: _____

Is an in-network exception possible on this plan (for instance, because there are no contracted midwives in the area)? yes no

If yes, phone# to call for exception: _____ If exception possible, fill out exception box** below.

If no, why isn't exception possible? _____ Who should set up the exception? Provider's office Member Either one

Additional notes on this VOB: _____

***Authorization** (Some insurance companies require an authorization # on claims in order for them to be processed; most do not require this.)

Name of insurance rep spoken to _____ Date _____ Time _____

Auth obtained? yes no pending Reference # while pending: _____

Approved authorization #: _____ Date Obtained: _____ Notes: _____

****In-Network Exception** (To have claims processed at the in-network rates for an out-of-network provider)

Name of insurance rep spoken to _____ Date _____ Time _____

Exception obtained? yes no pending Reference # while pending: _____

Approved Exception #: _____ Date Obtained: _____ Date range approved: _____

Notes: _____

If exception obtained, in-network bens are: Deductible amount: _____ Ded. left to meet: _____ % covered: _____

Codes authed (circle): 59400, 99205, 99215, 99354, 99355, 80055, A4550, 99350, 99461, 99213, 99464, S3620