Daughters of Sarah
Nursing & Rehabilitation Center

Insurance Verification

Patient Name _____Date of Birth _____

Primary Insurance Eligibility

Insurance Name:

Deductible $_____

Co-payment $_____

_____

Co-insurance $_____

Notes to Patient: _____

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Secondary Insurance Eligibility

Insurance Name:

Deductible $_____

Co-payment $_____

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Co-insurance $_____

Notes to Patient: _____

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We do our best to verify your benefits, but it is ultimately your responsibility to contact your insurer to best understand your benefits should you have any questions. Insurance can end your coverage at any time, with little to no notice. When that occurs, a 1 month advance of $14,070.90 and Security Deposit of $14,070.90 will be due. Also, Insurance doesn't pay to hold your room when you are hospitalized. If you opt to hold your bed while at the hospital, the private pay rate of $453.90 per day will be due.

Acknowledge Receipt of Insurance Benefit Information on _____ (date):

Print Name:_____ Signature:_____

Business Office Verified by _____ on _____.