DOVER WOMEN'S HEALTH, P.A.
700 Central Ave.
Dover, NH 03820
(603) 742-2424

NEXPLANON COVERAGE VERIFICATION

Patient Name: _____ Date of Birth: _____

Insurance Plan Name: _____ Subscriber ID# _____

Due to a wide discrepancy on how coverage is provided for **NEXPLANON** under health insurance plans, we ask that you contact your health insurance plan to determine what amount they will pay for **both** the **NEXPLANON, and the insertion**. If it's a covered benefit, the **NEXPLANON insertion** is generally covered under your medical plan. For some plans, the **NEXPLANON** itself is covered under the medical plan, while for other plans it is considered a pharmacy benefit under the pharmacy plan.

To help you prepare for your own out of pocket expenses for this service, we ask that you contact your insurance plan. The insurance plan may need the "Billing" codes listed below in order to provide you with the benefit information:

BILLING/CPT CODE	PRICE
11981-Insertion only	$ 387.00
11976-Removal only	$ 392.00
11983-Removal with Reinsertion	$ 608.00
J7307 – **NEXPLANON**	$1,250.00

Please ask the insurance representative the following questions:

1. Are both the **NEXPLANON** & insertion covered under my policy? YES _____ NO**_____
   ****IF BENEFITS ARE NOT AVAILABLE, PAYMENT IN FULL IS EXPECTED AT THE TIME THE SERVICE IS RENDERED.**
2. If yes, is the **NEXPLANON** covered under my ***medical*** or ***pharmacy*** plan? _____
3. If under the pharmacy plan, is there another telephone number I need to call? Tel# _____
4. What is the benefit coverage for the **NEXPLANON INSERTION (code 11981)?**

   Deductible Amount: _____ Has my deductible been met?:_____

   Coinsurance/Copay Amount: _____
5. What is the benefit coverage for the **NEXPLANON DEVICE (code J7307)?**

   Deductible Amount: _____ Has my deductible been met?:_____

   Coinsurance/Copay Amount: _____
6. Will the **doctor** be **paid directly**, or do I need to pay up front? _____
7. If the **NEXPLANON** device is covered by the pharmacy plan, what form is needed to submit the claim for payment, and how do I obtain the form? _____
8. Representative's name:_____ Reference #_____
   Date of Call: _____

Please ***contact our office to schedule your appointment*** and provide a copy of this completed form to our office prior to the appointment. We will attempt to re-verify these benefits.

INSURANCE COMPANIES SOMETIMES MISQUOTE BENEFIT INFORMATION.
DOVER WOMEN'S HEALTH, P.A. IS NOT RESPONSIBLE FOR MISQUOTED BENEFITS, AND PAYMENT FOR THIS ELECTIVE SERVICE IS THE PATIENT'S RESPONSIBILITY. WE SUGGEST YOU KEEP THIS FORM UNTIL INSURANCE PAYMENT HAS BEEN RECEIVED