Insurance Eligibility Verification Checklist

Verify before the visit. Half of denials trace to data captured here. | ClinicOps

Run this for every patient, before the date of service. Missing or inaccurate data is the number one driver of denials (Experian, 2025), and almost all of it is captured or verified at this step. Catch it here and you prevent the denial before the claim exists.

1 CAPTURE (into your EHR / PM system)

- ☐ Patient legal name and date of birth, spelled exactly as on the insurance card
- ☐ Insurance card scanned, front and back; secondary insurance card if any
- ☐ Subscriber name and the patient's relationship to the subscriber

2 VERIFY WITH THE PAYER (portal or phone)

- ☐ Coverage is active on the date of service
- ☐ Member ID and group number match the card exactly
- ☐ Plan is in-network for your practice and provider
- ☐ The scheduled service is a covered benefit
- ☐ Prior authorization or referral required for this service? If yes, start it now

3 FINANCIAL

- ☐ Copay, deductible (and how much is met), coinsurance, and out-of-pocket maximum
- ☐ Estimated patient responsibility calculated and communicated before the visit

4 COORDINATION OF BENEFITS

- ☐ Primary versus secondary payer confirmed
- ☐ Coordination of benefits is current with the payer (a stale COB is a common denial)

5 RECORD

- ☐ Verification date, who verified, and the payer reference or call-tracking number logged
- ☐ Any mismatch or coverage gap flagged and resolved before the patient arrives

THE ONE RULE: Patient identifiers live in your EHR or PM system. In any project board or tracker, reference the patient by chart number only. Never put names, DOB, or diagnoses in a board.