

INSURANCE INFORMATION

WE WILL NEED TO MAKE A COPY OF YOUR INSURANCE CARD

Primary Insurance _____

Insurance Company Phone Number _____

Subscriber ID# _____

Group# _____

Patient Name _____

Patient DOB _____

Name of Insured _____

Relationship to Patient _____

Insured's SS# _____

Is there a secondary insurance? Yes or No

If so, please provide Insured's Name and ID#.

OFFICE USE:

Today's Date _____

Policy Effective Date _____

Deductible? Yes or No Deductible Amount? _____

Amount Satisfied _____

Co-pay/Coinsurance _____ Visit limitations _____

Certification Required? Yes or No Certification # _____

of visits Authorized _____

Mail Claims Address _____