Insurance Verification

Patient Name_____

Patient Address_____

City, State, Zip (must have)_____

Patient Phone #_____

Patient Date of Birth_____ Male_____Female_____

Patient, Subscriber # / ID #_____

Group #_____

Insured Name & ID # (if different from patient) _____

Relationship to Insured____Self____Spouse____Child____Other____

Single ___ Married___ Other___

Insurance Co. Name_____

Ins. Co. Phone #_____

Claim # if an accident_____

Date of Accident/Injury_____

Other Info_____

TO BE COMPLETED BY OFFICE STAFF ONLY:

No Coverage_____ Coverage_____

Deductible $_____ Amount Met_____

Visits per Year_____ Allowable %_____ Other _____

Acupuncture Yes / No Units / Visits_____

Office Visits Yes / No

PT Yes / No Units / Visits _____