



INSURANCE VERIFICATION

Date _____

Patient Name: _____
Last Name, First 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 ___

Insurance Co Name: _____

Ins. Co. Phone #: _____

Claim # if an accident: _____

Date of Accident/ Injury: _____

Other Info: _____

To be completed by office staff: **Date Verified:** _____

Effective Date: _____ Spoke To: _____

Deductible \$ _____ Amount met \$ _____

Acupuncture Yes / No # of Visits _____ % allowed _____

PT Yes / No # of Visits _____ % allowed _____

Office Visit Yes / No

Insurance Company Address: _____
