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:_____ 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:

NO Coverage:_____ Coverage:_____

Deductible $ _____ Amount met $ _____

Visits per year _____ Allowable % _____ Other_____

Acupuncture Yes / No Units / Visits _____

Office Visit Yes / No

PT Yes / No Units / Visits _____ sab0607

Complete form and fax to: 954-389-0641