

Insurance Verification

We would like a link from the home page to this form that a potential patient could fill out then submit which would email us the information.

A disclaimer should be present noting a 48 hour business day turn around and that the patient will need to bring current insurance information including the policy number. A disclaimer should be present noting that if information is not completed it will delay the response time already stated.

CONFIDENTIAL PATIENT INFORMATION

PRIMARY Insurance Verification Form Date ___/___/___

Dr. _____ DATE & TIME OF APPT. _____

PATIENT NAME _____
LAST NAME FIRST MIDDLE INITIAL

PATIENT'S Phone Number _____ PATIENT'S Birthday _____

INSURED'S NAME _____
LAST NAME FIRST MIDDLE INITIAL

ADDRESS _____

PHONE NUMBER _____ PLACE OF EMPLOYMENT _____

BIRTHDAY _____ ID# _____ GROUP# _____

INSURANCE CO. _____ PLAN _____

INSURANCE COMPANY PHONE#(_____) _____ (to verify coverage)

Secondary Insurance Verification Form

PATIENT NAME _____
LAST NAME FIRST MIDDLE INITIAL

INSURED'S NAME _____
LAST NAME FIRST MIDDLE INITIAL

INSURANCE CO. _____

ID# _____ GROUP# _____ PLAN _____

INSURANCE COMPANY PHONE # (_____) _____ (to verify coverage)