INSURANCE VERIFICATION FORM

DATE: _____

Patient name: _____

Patient SS # _____ Patient DOB: _____

Insured's Name/ SS #/ DOB (if different from above):

_____

_____

Primary Insurance Company & Claim Mailing Address:

_____

_____

Phone # : _____

Group # : _____

ID # : _____

Spoke with: _____

Effective Date of Coverage: _____

Deductible: _____ Met / Not Met

% of Payment: _____

Co-payment: _____ Visit Cap Per Year: _____

Visits Used This Year: _____

Are Office Visits/ X-rays/ Modalities Covered? _____

Do you have an HRA or flex account? _____ Balance: _____

Additional Information: _____

_____

_____

_____