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INSURANCE BENEFITS VERIFICATION FORM

Name: _____ DOB: _____

_____ Male _____ Female School _____

Parent/Guardian Names: _____

Address: _____

Phone Number: _____ Cell Phone Number: _____

E-mail: _____ Please circle preferred method of communication.

Diagnosis (Please include ICD-9 Code if known): _____

Primary Physician: _____

Physician's Phone and Address: _____

Referring Physician (if different): _____

Referring Physician's Fax (required): _____

Insurance Information:

Primary Insurance: _____ Name of Insured: _____

Insured Date of Birth: _____

Employer: _____ Employer Address: _____

Member ID: _____ Group # _____ Effective Date: _____

Claims Address (found on back of card): _____ Cust Service #: _____

Secondary Insurance: _____ Name of Insured: _____

Member ID: _____ Group #: _____

Claims Address (found on back of card): _____ Cust Service #: _____

Medicaid Number: _____ Effective Date: _____

Signature: _____ Date: _____