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Insurance Verification Form

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:_____

Insurance 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