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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

Insurance Company Address: _____