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Insurance Verification Form

We encourage all patients to verify their insurance benefits prior to their first visit to fully understand your policy and treatment coverage. Please call the customer service number on the back of your insurance card.

Name of Patient: _____DOB: ____/___/_____ Relationship to Patient: _____

Policy Holder's Name: _____ DOB: ____/___/_____

Primary Insurance: _____ID#: _____ Group ID#_____

Insurance Phone Number: _____ Insurance Address: _____

Secondary Insurance: _____ID#: _____ Group ID#_____

Insurance Phone Number: _____ Insurance address: _____

Effective date of the policy: ____/___/_____

Is my provider contracted under my plan? ☐ Yes ☐ No

What is your co-payment amount? $_____

What is your plan based on? ◯ Calendar year ◯ fiscal year

Is there a deductible for my policy? ☐ Yes ☐ No

Submit Reset Print