

**Insurance Verification**

Patient 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 \_\_\_

Single \_\_\_ Married \_\_\_ Other \_\_\_

Insurance Co. Name \_\_\_\_\_

Ins. Co. Phone # \_\_\_\_\_

Claim # if an accident \_\_\_\_\_

Date of Accident/Injury \_\_\_\_\_

Other Info \_\_\_\_\_

**TO BE COMPLETED BY OFFICE STAFF ONLY:**

No Coverage \_\_\_\_\_ Coverage \_\_\_\_\_

Deductible \$ \_\_\_\_\_ Amount Met \_\_\_\_\_

Visits per Year \_\_\_\_\_ Allowable % \_\_\_\_\_ Other  
\_\_\_\_\_

Acupuncture Yes / No Units / Visits \_\_\_\_\_

Office Visits Yes / No

PT Yes / No Units / Visits \_\_\_\_\_