1: INSURANCE VERIFICATION

Patient

First name: ______________________ Middle name: ______________________

Last name: ______________________ Date of birth: ______________________

Sex: ______________________ Last 4 of SS: ______________________

Contact Information

Phone #: ______________________ Email: ______________________

Address: ____

Contact me by: ☐ Email ☐ Phone call ☐ Text

Insurance Company

Name: ____

Address: ____

Phone #: ______________________

Insurance Policy

Type of policy: ☐ Commercial ☐ Medicare ☐ VA ☐ TriWest ☐ W/C ☐ Other

Member ID: ______________________ Group #: ______________________

Who is the primary insured (policy holder)? ☐ Patient ☐ Spouse ☐ Partner ☐ Other

If the patient is the primary insured (policy holder) ➔ SKIP NEXT STEP

If the patient is NOT the primary insured (policy holder) ➔ CONTINUE

Primary Policy Holder

Last name: ______________________ First name: ______________________

Middle name: ______________________ Date of birth: ______________________

Sex: ______________________ Last 4 of SS: ______________________

Attach the front and back of the insurance card here:

FAX to 866-271-1923 or **EMAIL** to 8883542758@usa.com or **TEXT** to 321-216-9000