Insurance Information

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