

# ATLANTIC COAST MEDICAL CARE, L.L.C.

13171 ATLANTIC BLVD. SUITE 1

JACKSONVILLE, FL 32225

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## **INSURANCE INFORMATION**

In order for our office to expedite your requests, please provide below the contact information for your Insurance Company:

Insurance Company: \_\_\_\_\_

ID # \_\_\_\_\_

Phone \_\_\_\_\_

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date