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Annapolis Healing

INSURANCE VERIFICATION Date _____

Patient Name: _____ _____
Last Name, First 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 _____

Insurance Co Name: _____

Ins. Co. Phone #: _____

Chief Complaint or Primary Diagnosis: _____

Claim # if an accident: _____

Date of Accident/Injury: _____

Other Info: _____

To be completed by office staff: **Date Verified:** _____

Effective Date: _____ **Spoke To:** _____

Deductible _____ **Amount met** _____

Acupuncture ___ Yes / ___ No # of Visits _____ % allowed _____%

Any Restrictions? Diagnosis , Provider type...

_____

_____

PT ___ Yes / ___ No # of Visits _____ % allowed _____%

Office Visit ___ Yes / ___ No

Insurance Company Address:

_____

_____