Insurance Verification Form

Patient Name:	Date of Verification:
Patient Phone Number:	Date of Birth:
Social Security Number:	Doctor the patient is seeing:
Appointment Time & Date:	Chief Complaint:
Primary Insurance Company:	Network:
PSP (if in an HMO or POS plan):	Name of insured person:
Relationship to patient:	Insured's date of birth:
Insured's Social Security Number:	Employer:
Effective Date:	

Person Contacted: Telephone Number:

Who is covered under this plan?

Send Claim to:	Deductible:
Group Number:	For Individual:
Policy Number:	For Family:
Co-Pay:	
Policy Notes:	
Immunizations:	Lab & Diagnostic Tests:
Well Visits:	Other: