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**REQUEST FOR VERIFICATION OF BENEFITS**  
**DR. DOMINIQUE VONADOR, DOM, Lac, AP**

INDIV. NPI: 1063823045 GROUP NPI: 1982016002

**PATIENT INFORMATION:** **APPOINTMENT DATE:** \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**HOME PHONE:** \_\_\_\_\_ **WORK/CELL:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **GENDER: MALE FEMALE**

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_ **MARRIED: YES NO**

**SSN (OPTIONAL):** \_\_\_\_\_

**INSURANCE INFORMATION:**

**PRIMARY INSURANCE CARRIER:** \_\_\_\_\_

**MEMBER ID #:** \_\_\_\_\_ **GROUP #:** \_\_\_\_\_

**TELEPHONE #:** \_\_\_\_\_

**INSURED'S NAME:** \_\_\_\_\_ **INSURED'S DOB:** \_\_\_\_\_

**SECONDARY INSURANCE CARRIER:** \_\_\_\_\_

**MEMBER ID #:** \_\_\_\_\_ **GROUP #:** \_\_\_\_\_

**TELEPHONE #** \_\_\_\_\_

**INSURED'S NAME:** \_\_\_\_\_ **INSURED'S DOB:** \_\_\_\_\_

**W.C. OR AUTO:**

**INSURANCE CARRIER:** \_\_\_\_\_

**CLAIM #:** \_\_\_\_\_ **DATE OF INJURY:** \_\_\_\_\_

**ADJUSTER:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_