INSURANCE INFORMATION

Patient Information: (Needed to Verify Insurance Coverage)

Patient Name: _____

Patient Date of Birth: _____

Insured's Name: _____

Insured's Date of Birth: _____

Insured's Social Security #: _____

Insurance Company Name: _____

Claims Mailing Address: _____

_____

Insurance Co. Phone #: _____

Group Name: _____

Group Number: _____

Identification #: _____

For Office Use Only:

Date: _____

Verify By: _____

Representative: _____

Effective Date: _____

Out of Ntwk. (non-provider) Ortho Benefit: _____

Age Limit: _____

Used: _____ **$ Available:** _____

Percentage Covered: _____ **Deductible amount:** _____

Claims Filed:

◯ **Monthly** ◯ **Quarterly** ◯ **Initial Fee Considered**

◯ **Auto Monthly** ◯ **Auto Quarterly** ◯ **Based on Billing**