INSURANCE VERIFICATION FORM

The following information is needed to file your claim:

Policy Holder: _____

Date of Birth: _____

Employer: _____

Patient's Name: _____

Insurance Company: _____

ID Number: _____ Group Number: _____

Product Type: _____ HMO_____PPO_____POS_____EPO_____POS/PPO _____HMO/PPO

Claims Address: _____

Phone Number: _____

Co-Payment Amount: _____

Effective Date: _____

Parent's/Patient's Signature: _____ Date: _____