INSURANCE VERIFICATION FORM and
INVOICE AND BILLING

Name: ____

Address: ____

Phone: ____

DOB: ____

SSN: ____

Name of Insured (if different)____

DOB of Insured (if different) ____

Insurance Co: ____

Claims Address: ____

Insurance Phone Number: ____

Insurance ID: ____

Insurance Group Number: ____

Effective Date: ______________________ **Deductible: Y N met?**__________

Benefit % :__________________ **Copy of %:** ___________________________

Contract Year max Visits ____

Pre Authorization Required? ____

Diagnosis: ____

Authorization #: ____

Date of Authorization: _______________**Contact Name:** ___________________

Notes: ____

____

____

Signature: ___________________________________

Date: _______________________________________