Insurance Questionnaire

The following questions are necessary so that we may properly verify your insurance benefits for you. These questions are taken directly from the insurance form that we must fill out and call your health insurance carrier regarding your health benefits. Please answer as fully as possible.

1. Type of insurance: BCBS______ AETNA______ CIGNA_________ UHC___________
   PPO__________ HMO___________
2. Patient Name:____
3. Insured's Name (as it appears on the insurance card):_______________________
4. Patient's Address:____
   City________________________State_______ Zip________Tel #____________________
5. Insured's Date of Birth____
6. Patient Social Security #____
7. Insured's Name Member ID#____
   Insured's Group Number:____
   Insurance Plan Name or Program Name:______________________________________

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to verify my insurance benefits.

Signed: ____Date:________________