

ANNIE STURMAN, A.P.

INSURANCE VERIFICATION

Patient Name:

Patient Address:

MUST INCLUDE ZIP CODE:

Patient Phone #:

Patient Date of Birth:

Male:

Female:

Patient Subscriber #/ ID #/ Account #:

Group #:

Insured Name and ID # (If different from patient):

Relationship to Insured:

Single

Married

Other

Insurance Co. Name:

Insurance Co. Phone #:

Claim # if an accident:

Date of Accident/Injury:

Other Info:

To be completed by office staff:

NO Coverage: _____ Coverage: _____

Deductible \$ _____ Amount met \$ _____

Visits per year _____ Allowable % _____ Other _____

Acupuncture Yes/No Units/ Visits _____

Office Visit Yes/ No

PT Yes/ No Units/ Visits _____