Stephen H. Dell-Jones, A.P.

INSURANCE VERIFICATION **Date_____**

Patient Name: _____
Last Name, First Name
Patient Address: _____

City, State & Zip(Must Have)_____

Patient Phone #: _____

Patient Date of Birth:_____Male: ____ Female: _____

Patient, Subscriber # / ID #: _____

Group #: _____

Insured Name & ID# (if Different from patient) _____

Relationship to Insured:_____Self_____Spouse_____Child_____Other_____

Insurance Co Name: _____

Ins. Co. Phone #: _____

Chief Complaint or Primary Diagnosis: _____

Claim # if an accident:_____

Date of Accident/ Injury:_____

Other Info: _____

To be completed by office staff: Date Verified:_____

Effective Date:_____ Spoke To:_____

Deductible $ _____ Amount met $ _____

Acupuncture Yes / No # of Visits _____ % allowed _____
Any Restrictions ? Diagnosis , Provider type…_____

PT Yes / No # of Visits _____ % allowed _____

Office Visit Yes / No

Insurance Company Address:_____
_____

sab 07/12