**INSURANCE VERIFICATION FORM**

Full Name: **\***

Address 1: **\***

Address 2:

State: **\***  City: **\*** Zip: **\***



Home Phone: **\*** Cell Phone:



Email:



Your DOB: **\*** Month\_\_\_\_, Day\_\_\_\_\_, Year \_\_\_\_\_\_ Sex **\***

Patient, Primary Subscriber# / ID: **\***

Group #: **\***

Insurance Type: **\***

Insured Name & ID#(if different from Patient):

Relationship to insured: **\***

Marital Status: **\***

Insurance Company Name: **\***

Ins. Co. Phone #: **\***

Claim # if accident:

Date of Accident/Injury:

Condition or illness you are seeking treatment for: **\***

Referred By: **\***

Other Information:

By submitting this form, I understand that my personal information will be used ONLY for the insurance verification process.  It will be accessible to the staff at Danielle DeFreitas and to a third party biller (CBC Medical Management). I understand that I have the right to request any and all restrictions to the use of disclosure of my information.