Insurance Verification Information

Doctor			**C A Initials**			**Verified on**	
Patient #			**Computer #**			**Case type**	
Patient Name						**D O B**	
Insured's name						**D O B**	
Relationship			**Since (Date)**			**Injured / ill since**	
Employer						**Phone**	
Address						**Supervisor**	
City		**State**		**Zip**		**Note**	
Insurance Company						**Phone**	
Address						**Insured's ID**	
City		**State**		**Zip**		**Group #**	
Contact		**Title**		**Phone**		**Claim #**	
Notes							

Primary or Secondary insurance	
Diagnosis	
Treatment prescribed	
Policy effective from	
Deductible amount per year	
Deductible met?	
Max payment for initial visit	
Max payment covered per visit	
Max ceiling for X-ray and other diagnostics	
Max number of visits covered per year	
Items expressly not covered	
Items requiring specific tests & confirmation	
Other notes and comments	