**INSURANCE VERIFICATION FORM**

**PATIENT INFORMATION**

**Full Name:**

**Address 1:**

**Address 2:**

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

**Home Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email:**

**Date of Birth:** **/**/\_\_\_\_\_\_  
Month Day Year

**Sex:** ☐ Male ☐ Female ☐ Other

**INSURANCE INFORMATION**

**Patient/Primary Subscriber ID:**

**Group #:**

**Insurance Type:** ☐ Primary ☐ Secondary ☐ Other

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

**Relationship to Insured:** ☐ Self ☐ Spouse ☐ Child ☐ Other

**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

**Insurance Company Name:**

**Insurance Company Phone #:**

**TREATMENT INFORMATION**

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

**Referred By:**

**Claim # (if accident):**

**Date of Accident/Injury:**

**Other Information:**

**CONSENT AND AUTHORIZATION**

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.

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_

**Print Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_