Insurance Communications Form

Tax ID: 20-324-6974

Today's Date:____/____/____

Patient Name:_____ DOB:___/___/___

Subscriber

Subscriber Name:_____ DOB:___/___/___

Subscriber ID #:_____ Subscriber's relationship to patient:_____

Employer Name:_____ Employer phone #:(____)_____

Employer Address: _____

City:_____State:____Zip:_____

Insurance

Insurance Co. Name:_____ Phone #:(____)_____

Insurance Address: _____

City:_____State:____Zip:_____

Group #_____ Fax#(____)_____

----------**Office Use Only**----------

Date:____/____/____ Staff who called:_____ Insurance Rep:_____

Lifetime Max:$_____ Remaining Max:$_____ Payable at:_____%

Deductible: $_____ Waiting Period: _____

Age limitations: Child_____yrs Adult: yes no

Frequency of Claims: monthly quarterly other: