INSURANCE VERIFICATION FORM 19-20

Today's Date:____________________

PATIENT INFORMATION

Patient Name:__________________________ Phone#:__________________

Student ID#__________________ Date of Birth:________________

Prescott Address:_____________________City:____________ State:_____

ZipCode:______ Campus Box # ________

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Primary Insurance Company:______________________________________

Policy/Member ID#:___________________________ Group#:____________

Insurance address:____

Are you the Policy holder? (circle one) YES NO

Policyholder's Name:__________________ Date Of Birth:_______________

Street address:____

City:________________ State:____________ Zip Code:___________

Home phone#:____

Patient's relationship to the Policyholder? (circle one)

SELF CHILD SPOUSE OTHER