

**INTERNET INSURANCE VERIFICATION FORM**

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ Zip \_\_\_\_\_

Patient's S.S.# \_\_\_\_\_ Referred by: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's S.S.# \_\_\_\_\_

Insurance Company \_\_\_\_\_

Phone Number of Insurance Co: \_\_\_\_\_

Claims Mailing Address (on card) \_\_\_\_\_

Member #: \_\_\_\_\_ Group #: \_\_\_\_\_

**PLEASE FAX COMPLETED FORM TO (561) 338-3651**