

# Insurance Verification

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address: \_\_\_\_\_ SS# \_\_\_\_\_  
\_\_\_\_\_  
Sex M F  
Phone: home \_\_\_\_\_  
work \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Relationship: \_\_\_\_\_ SS# \_\_\_\_\_

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Provider Name: John R. Law, DC Location: Joint & Spine  
Provider Tax ID 204400424 Center of Medford  
Name of Insurance Co:

Provider in Network?            yes            no

Date of Verification: \_\_\_\_\_ Phone# \_\_\_\_\_  
Spoke to: \_\_\_\_\_  
Ins ID# \_\_\_\_\_ Group # \_\_\_\_\_

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## Benefits

### In Network

### Out of Network

Effective Date		Effective Date	
Deduct	any met?	Deduct	any met?
Copay		Copay	
Coins		Coins	
Referral Required?		Referral Required?	
Pre-cert Required?		Pre-cert Required?	
Limits?		Limits?	

Referring Doctor: \_\_\_\_\_ Claims Submission Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_