Your Hospital's Logo Here

INSURANCE VERIFICATION FORM

TODAY'S DATE:	
DATE RECEIVED:	
WORK COMP:	
AUTO ACC:	
OTHER	

PATIENT NAME:	(Last)	(First)	(Middle)
ADDRESS:			
SOCIAL SECURITY #:		DATE OF BIRTH:	
HOME PHONE:		WORK PHONE:	
DIAGNOSIS:			PHYSICIAN
TYPE OF THERAPY: ☐ SP ☐ PT ☐ OT ☐ Aquatic Therapy *(Check all that apply)*			LENGTH OF STAY:

PRIMARY INSURANCE

PRIMARY CARRIER:		POLICY #:
POLICY HOLDER:		GROUP #:
POLICY HOLDER'S EMPLOYER:		EFFECTIVE DATE:
INSURANCE PHONE #:	CONTACT PERSON:	
COVERAGE PERCENTAGE:	DEDUCTIBLE:	PATIENT RESPONSIBILITY:
INSURANCE BILLING ADDRESS:		
INSURANCE REP:		DATE VERIFIED:

SECONDARY INSURANCE

PRIMARY CARRIER:		POLICY #:
POLICY HOLDER:		GROUP #:
POLICY HOLDER'S EMPLOYER:		EFFECTIVE DATE:
INSURANCE PHONE #:	CONTACT PERSON:	
COVERAGE PERCENTAGE:	DEDUCTIBLE:	PATIENT RESPONSIBILITY:
INSURANCE BILLING ADDRESS:		
INSURANCE REP:		DATE VERIFIED: