



Insurance Information Form

Patient's Name:	Date of Birth:
Address:	Phone Number:
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Type of Coverage: <input type="checkbox"/> Commercial ID#: _____ (Please attach front and back of insurance card) <input type="checkbox"/> Worker's Compensation Employer Name and Address: _____ _____	Worker's Compensation: Claim #: _____ WCB #: _____ Date of Injury: _____
Primary Insurance:	Secondary Insurance:
Address:	Address:
Customer Service (Commercial Carriers): Phone#:	Customer Service (Commercial Carriers): Phone#:
Case Manager/Claim Adjuster Name: Phone#: Fax#:	Case Manager/Claim Adjuster Name: Phone#: Fax#:
Insured's Name & ID# (if other than patient):	Insured's Name & ID# (if other than patient):
Group/Policy #:	Group/Policy #:

Authorization Information:

Has prior authorization been obtained from the insurance carrier for the physician's services?
 Yes (Please attach authorization letter) Auth#: _____ (If verbal) No

Please fax completed form to your case manager.