Synergie Holistic Medicine, Inc.

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DATE: _____|_____|_____

INSURANCE VERIFICATION

Patient Name: _____
Last Name First Name

Patient Address:_____

City:_____ State:_____ Zip (Must Have):_____

Patient Phone #:_____

Patient Date of Birth: _____|_____|_____ Male: _____Female: _____

Patient Subscriber # / ID #:_____

Group #:_____

Insured Name & ID # (if different from Patient):_____

Relationship to Insured: Self:_____ Spouse: _____ Child: _____ Other: _____

Insurance Co. Name:_____

Insurance Co. Phone #:_____

Claim # (if an accident):_____

Date of Accident/Injury: _____|_____|_____ Other Information:_____

_____

TO BE COMPLETED BY OFFICE STAFF Date Verified: _____|_____|_____

Effective Date: _____|_____|_____ Spoke To:_____

Deductible: $_____ Amount met: $_____

Acupuncture: Yes_____ No_____ # of visits: _____ % Allowed: _____

Office Visit: Yes_____ No_____

PT: Yes_____ No_____ # of visits: _____ % Allowed: _____

Insurance Company Address:_____

_____