Medical Insurance Verification Form Template

Please Print and email this to the Clinic.

Patient Information

Name *

First Name Last Name

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Phone Number *

Email *

example@example.com

Date of Birth *

Month Day Year

Gender *

Social Security Number *

Insurance Information

Primary Insurance Co *

Policy No *

Group No *

Primary Insurance Phone No *

Subscriber's Name *

First Name Last Name

Date of Birth *

Month Day Year

Subscriber's Relationship to Patient *

Secondary Insurance Co *

Policy No *

Group No *

Secondary Insurance Phone No *

Subscriber's Name *

First Name Last Name

Date of Birth *

Month Day Year

Subscriber's Relationship to Patient *

Insurer Information

Name of Insurer *

Name of Insurance Rep *

First Name Last Name

Rep Phone Number *

Referral Contact Name *

First Name Last Name

Referral Phone Number *

Notes