Jackson and Lujan EYE CARE CENTER

INSURANCE INFORMATION

Please fill out all information below since we will need this to obtain insurance authorization and to check benefit eligibility. If you have multiple members of your family that you would like for us to verify eligibility, only one form is needed with all the patient names and date of births listed below.

Insurance Company:_____

Primary Insured Name:_____
Primary Insured Date of Birth:_____

Last 4 digits of Social Security:_____

Insurance Member ID#:_____

Place of employment:_____

Contact phone number:_____

All Patients Names Date of birth

1._____

2._____

3._____

4._____

5._____

6._____