INSURANCE VERIFICATION FORM

INSURED INDIVIDUAL INFORMATION

Name: _____ Sex: ☐ Male ☐ Female
Date of Birth: _____ Social Security Number: _____
Street Address: _____
City: _____ State: _____ ZIP Code: _____
Phone: _____ E-Mail: _____

INSURANCE COMPANY

Insurance Company: _____ Phone: _____
Insurance Company is: ☐ Primary Insurer ☐ Secondary Insurer
Agent Contact Name: _____ Fax: _____
Policy Number: _____ Group Number: _____
Subscriber Name: _____ Date of Birth: _____
Subscriber Relationship to Insured: _____

ELIGIBILITY

Coverage Start Date: _____ Coverage End Date: _____
Policy Type: _____
Deductible: $_____ Has Deductible Been Met? ☐ Yes ☐ No
Copayment: $_____ Coinsurance: ____% Out-of-Pocket Limit: $_____

COVERAGE

Describe the insurance coverage, including any benefits, limitations, and exclusions:

Signature: _____ Date: _____

Print Name: _____