The following form may be copied and used to record benefit information on patients.

Patient's Name _____ DOB _____

Address _____ _____ SS# _____

_____

Insurance Carrier _____Phone _____

ID# _____ Group# _____

Effective date _____

Auth required _____sometimes a different # needs to be called_____

Referral required _____

Deductible ___yes ___ no $_____ amount _____If deductible paid _____ how much _____

Copay _____

# of visits allowed _____

OTR required ___yes ___ no when required_____

Address for claims submission _____

_____

Are we in network with you? _____yes _____no