APPENDIX P
SAMPLE BENEFITS VERIFICATION FORM

PLEASE FILL IN THE BLANKS BELOW, SO WE CAN KEEP THIS INFORMATION IN YOUR PATIENT FILE:

PATIENT'S NAME _____

ADDRESS_____

_____

DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____

NAME OF INSURANCE PLAN_____

INSURANCE POLICY NUMBER_____

GROUP NUMBER_____

NAME OF EMPLOYER PROVIDING POLICY _____

INSURED'S NAME (IF DIFFERENT FROM PATIENT)_____

INSURED'S SOCIAL SECURITY NUMBER_____

INSURED'S DATE OF BIRTH _____