CONFIDENTIAL INSURANCE COVERAGE REQUEST FORM

The information on this form is confidential and will only be divulged to your insurance company. Please do not list your social security number. If you have any questions, please contact us at (760) 635-0581.

Patient Name:_____ Date:_____

Patient Insurance ID#:_____ Patient Birthdate:_____

Name of Insured:_____ Insured Birthdate:_____

Insured Insurance ID:#_____ Name of Employer:_____

Name of Insurance Company:_____ Type of Plan:_____

Group ID#:_____ Eligibility Phone # (on back of card):_____

Address to send claims to: (on back of card)_____

_____

Is there another health benefit plan? If yes, please fill out the information below:

Patient Name:_____ Date:_____

Patient Insurance ID#:_____ Patient Birthdate:_____

Name of Insured:_____ Insured Birthdate:_____

Insured Insurance ID:#_____ Name of Employer:_____

Name of Insurance Company:_____ Type of Plan:_____

Group ID#:_____ Eligibility Phone # (on back of card):_____

Address to send claims to: (on back of card)_____

_____

Please complete and fax this form to our office at (760) 635-0587.
(please check one)

___ Please call me at: _____ with the results of the eligibility check.

___ Please email me at: _____ with the results of the eligibility check.

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