

# INSURANCE INFORMATION

Please fill out all of the appropriate information

## MEDICARE / MEDICAID

Medicare No. \_\_\_\_\_ Effective Date \_\_\_\_\_  
Medicaid No. \_\_\_\_\_ Date or Month Eligible \_\_\_\_\_  
State in which it was issued \_\_\_\_\_

## PRIVATE INSURANCE - Primary

Name of Policy Holder \_\_\_\_\_  
Policy Holders SSN# \_\_\_\_\_ Sex \_\_\_\_\_ DOB \_\_\_\_\_  
Policy Holders Employer \_\_\_\_\_  
Patient's Relationship to Policy Holder Self Spouse Child Other Effective date of Coverage \_\_\_\_\_  
ID/Policy # \_\_\_\_\_ Group No. \_\_\_\_\_  
Name of Insurance Company \_\_\_\_\_

## PRIVATE INSURANCE - Secondary

Name of Policy Holder \_\_\_\_\_  
Policy Holders SSN# \_\_\_\_\_ Sex \_\_\_\_\_ DOB \_\_\_\_\_  
Policy Holders Employer \_\_\_\_\_  
Patient's Relationship to Policy Holder Self Spouse Child Other Effective date of Coverage \_\_\_\_\_  
ID/Policy # \_\_\_\_\_ Group No. \_\_\_\_\_  
Name of Insurance Company \_\_\_\_\_

## ACCIDENTS-Auto-Other

***If your injury is a result of an auto accident, please fill out this section***

Policy Holders Name \_\_\_\_\_  
Policy Holders Address \_\_\_\_\_  
Auto Insurance Co. Name \_\_\_\_\_ Policy No. \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_ Date Accident Occurred \_\_\_\_\_  
How Did Accident Occur? \_\_\_\_\_  
\_\_\_\_\_  
Attorney's Name \_\_\_\_\_ Address \_\_\_\_\_

## WORKMEN'S COMPENSATION

***If your injury is a result of an accident that occurred on the job, please fill out this section***

Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Date of Injury \_\_\_\_\_ Was Injury Reported to Employer? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, whom may we contact for verification?  
Name \_\_\_\_\_ Tel. No. \_\_\_\_\_  
Authorization No. \_\_\_\_\_ Claim No. \_\_\_\_\_  
Are we listed on your panel of physicians through your employer? YES \_\_\_\_\_ NO \_\_\_\_\_  
Tell us how injury occurred \_\_\_\_\_