

VERIFICATION OF ELIGIBILITY & BENEFITS FORM

LOCATION: SP _____ PAT _____ JC _____ RAND _____

IME _____ PERM _____ LOP _____ LIEN _____ S&F _____ ON CALL _____

TODAY'S DATE: _____ APPOINTMENT DATE: ____/____/____ TIME: _____
PATIENT'S NAME: _____ DOB: ____/____/____ SS#: ____/____/____
HOME #: _____ - _____ - _____ CELL #: _____ - _____ - _____ WORK #: _____ - _____ - _____
ADDRESS: _____ ZIP CODE: _____

\$240 MUST BE CASH OR CERTIFIED CHECK

BODY PART(S) _____

AUTO BENEFIT(S)

DOL: ____/____/____ CLAIM #: _____ INSURANCE COMP.: _____
INS. ADDRESS : _____
ADJUSTER: _____ PHONE #: _____ - _____ - _____ X
CLAIM EXHAUSTED YES NO

PIP BENEFIT LIMIT \$ _____ PIP BENEFIT AVAILABLE \$ _____

REFERRED BY: ATTORNEY: _____ PHONE #: _____ - _____ - _____
DOCTOR : _____ PHONE #: _____ - _____ - _____

DO YOU HAVE PVT. INS. YES NO

PRIVATE INSURANCE

PRIMARY INSURANCE: _____ PHONE NUMBER : ____/____/____
I.D. #: _____ GROUP #: _____ EFFECTIVE DATE: ____/____/____
CLAIMS/INSURANCE ADDRESS: _____
INSURED'S NAME: _____ SS#: ____/____/____ DOB: ____/____/____
COPAY \$ _____ DED \$ _____ (MET)\$ _____ CO-INS. ____/_____%

IS RADIOLOGY AUTHORIZATION NEEDED? YES NO FROM: _____

SECONDARY INSURANCE: _____ I.D. NUMBER: _____

WORKER'S COMP.

DOL: ____/____/____ CLAIM #: _____ CASE MANAGER: _____
PHONE #: ____/____/____ FAX #: ____/____/____ INSURANCE COMP.: _____
ADDRESS: _____

EMPLOYEE INITIALS: _____