



Gisele Leon-Ritch, D.O.M, A.P.

Tel: 954 435 4900  
Fax: 954 435 4922  
Email: dr.gisele@live.com

DATE: \_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_

## INSURANCE VERIFICATION

Patient Name: \_\_\_\_\_  
Last Name First Name

Patient Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip (Must Have): \_\_\_\_\_

Patient Phone #: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

Patient Subscriber # / ID #: \_\_\_\_\_

Group #: \_\_\_\_\_

Insured Name & ID # (if different from Patient): \_\_\_\_\_

Relationship to Insured: Self: \_\_\_\_\_ Spouse: \_\_\_\_\_ Child: \_\_\_\_\_ Other: \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Claim # (if an accident): \_\_\_\_\_

Date of Accident/Injury: \_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_ Other Information: \_\_\_\_\_

### **TO BE COMPLETED BY OFFICE STAFF**

Date Verified: \_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_

Effective Date: \_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_

Spoke To: \_\_\_\_\_

Deductible: \$ \_\_\_\_\_

Amount met: \$ \_\_\_\_\_

Acupuncture: Yes \_\_\_\_\_ No \_\_\_\_\_

# of visits: \_\_\_\_\_ % Allowed: \_\_\_\_\_

Office Visit: Yes \_\_\_\_\_ No \_\_\_\_\_

PT: Yes \_\_\_\_\_ No \_\_\_\_\_

# of visits: \_\_\_\_\_ % Allowed: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_