

**David Nevins, A.P.**

**INSURANCE VERIFICATION**

Patient Name: \_\_\_\_\_

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

\_\_\_\_\_

Phone: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

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

Patient ID# or SS#: \_\_\_\_\_

Policy or Group: \_\_\_\_\_

Insured Name & ID# (if Different) \_\_\_\_\_

Ins. Co. Phone #: \_\_\_\_\_

Claim #: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

Other Info: \_\_\_\_\_

Please Fax to (305) 940-7949

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For Office use:

AP:\_\_\_\_\_ MT/PT:\_\_\_\_\_ OFF Visit:\_\_\_\_\_ Deduct:\_\_\_\_\_ Met:\_\_\_\_\_

#of Visits:\_\_\_\_\_ Notes:\_\_\_\_\_ %:\_\_\_\_\_ Co.Pay:\_\_\_\_\_ Co.Ins:\_\_\_\_\_

Ins Year:\_\_\_\_\_