Health care information is personal and sensitive information related to a person's healthcare. It is being faxed to you after appropriate authorization from the patient or under circumstances that don't require patient authorization. You, the recipient, are obliged to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

REQUEST FOR VERIFICATION OF BENEFITS

CHUNYAN WANG, AP

PATIENT INFORMATION: **APPOINTMENT DATE:**_____

PATIENT NAME:_____**DOB:**_____

HOME PHONE:_____**WORK/CELL:**_____

ADDRESS:_____ **GENDER: MALE FEMALE**

CITY:_____**STATE:**_____**ZIP:**_____ **MARRIED: YES NO**

STUDENT / EMPLOYER:_____

REFERRING DOCTOR:_____**PHONE:**_____

SSN (OPTIONAL):_____

INSURANCE INFORMATION:

PRIMARY INSURANCE CARRIER: _____

MEMBER ID #:_____**GROUP #:**_____

TELEPHONE #:_____

INSURED'S NAME:_____**INSURED'S DOB:**_____

SECONDARY INSURANCE CARRIER:_____

MEMBER ID #:_____**GROUP #:**_____

TELEPHONE #_____

INSURED'S NAME:_____**INSURED'S DOB:**_____

W.C. OR AUTO:

INSURANCE CARRIER:_____

CLAIM #:_____**DATE OF INJURY:**_____

ADJUSTER:_____**PHONE #:**_____