



ACUPUNCTURE NOW

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Insurance Verification



OFFICIAL FLORIDA PANTHERS
MEDICAL TEAM

Patient Name: _____

Patient Address: _____

MUST INCLUDE ZIP CODE: _____

Patient Phone # _____

Patient Date of Birth: _____ Male: _____ Female: _____

Patient, Subscriber # / ID # : _____

Group #: _____

Insured Name & ID # (if different from patient) : _____

Relationship to Insured: _____ Single _____ Married _____ Other _____

Insurance Company Name: _____

Insurance Company Phone # : _____

Claim # if an accident: _____

Date of Accident Injury: _____

Other Info: _____

To Be Completed By Office Staff:

NO Coverage: _____ Coverage: _____

Deductible \$ _____ Amount Met \$ _____

Acupuncture YES / NO Units / Visits _____

Office Visit - YES / NO Allowable % _____

P / T - YES / NO Units / Visits _____

Visits Per Year _____ Other _____

PLEASE FAX BACK TO:

561 892 0773