Dr. Tony Willcox, D.O.M

Insurance Verification

Patient Name:____
Patient Address:____
MUST INCLUDE ZIP CODE:___________________________________
Patient Phone Number:_____________________________________
Date of Birth:____/______/________ Male:___________ Female:______________
Subscriber # / Member Id #:________________________________
Group / Account #:____
Insured Name & Id (if different from patient):___________________
Relationship to insured:_______________ Single:_____ Married:_____ Other:______
Insurance Company Name:___________________________________
Insurance Company Phone #:_________________________________
Claim # (if involved in accident):____________________________
Date of Accident injury: ____________________________________
Other Info:____

TO BE COMPLETED BY OFFICE STAFF ONLY:

In Network: YES / NO
Terminated:_______________
Deductible: $______________
Out of Pocket: $____________
Acupuncture: YES / NO
Office Visit: YES / NO
P / T: YES / NO
Co Pay: YES / NO
Medical Nesc. YES / NO
Rendered By: Licensed Physical OR Licensed Therapist

Out Of Network: YES / NO
Effective Date:_______________
Amount Met: $_______________
Amount Met: $_______________
# of Units / Visits:____________
Allowable:________________%
# of Units / Visits:____________
Renewal Month:_____________

PLEASE FAX BACK TO:

561-892-0773

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