

Family Resource Assoc., Inc.

**TECH**Connection

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### INSURANCE/MEDICARE VERIFICATION FORM

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Sex: M F  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work# \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security # \_\_\_\_-\_\_\_\_-\_\_\_\_ Marital Status: S M D W

#### **REFERRING PHYSICIAN/ THERAPIST:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Parent /Guardian of child: \_\_\_\_\_ Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

#### **INSURANCE INFORMATION:**

Name of Insured/Subscriber: \_\_\_\_\_ Employer: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Group #: \_\_\_\_\_ ID# \_\_\_\_\_  
Secondary Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name of Subscriber: \_\_\_\_\_ Employer: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Group #: \_\_\_\_\_ ID# \_\_\_\_\_ Subscriber date of birth: \_\_\_\_\_

I certify that the above information is correct. I AGREE TO PAY any fee that is not covered by my insurance.

Signature of responsible party: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE:** YOU MUST BRING YOUR INSURANCE/MEDICARE CARD W/ YOU ON YOUR 1<sup>ST</sup> VISIT.