



Ahuva Gamliel, ND, AP

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INSURANCE VERIFICATION FORM

Patient Name: _____

Patient Address: _____

City, State, Zip: _____

Patient Phone number: _____

Date of Birth: _____ Male/Female: _____

Patient Subscriber ID #: _____

Group#: _____

Relationship to insured: _____

Single/Married/Other: _____

Insurance Company name: _____

Insurance company phone #: _____

Claim # if accident: _____

Date of accident/injury: _____

Other info.: _____

TO BE COMPLETED BY OFFICE STAFF

NO Coverage _____ Coverage _____

Deductible: _____

Amount met: _____

Visits per year: _____ Office visit Yes/No

Allowable %: _____ PT Yes/No Units/Visits

Other: _____

Acupuncture Yes/No Units/visits: _____

Please complete and fax to 954.389.0641