Medical Insurance Forms

Doctor				C A Initials		Verified on	
Patient #				Computer #		Case type	
Patient Name						D O B	
Insured's name						D O B	
Relationship				Since (Date)		Injured / ill since	
Employer						Phone	
Address						Supervisor	
City		State		Zip		Note	
Insurance Company						Phone	
Address						Insured's ID	
City		State		Zip		Group #	
Contact		Title		Phone		Claim #	
Notes							

Primary or Secondary insurance	
Diagnosis	
Treatment prescribed	
Policy effective from	
Deductible amount per year	
Deductible met?	
Max payment for initial visit	
Max payment covered per visit	
Max ceiling for X-ray and other diagnostics	
Max number of visits covered per year	
Items expressly not covered	
Items requiring specific tests & confirmation	
Other notes and comments	