Print Form

Insurance Verification Form

Patient Name: _____ Patient Date of Birth: _____

Patient Social Security Number: _____

Primary Insured is the Policy Holder or Subscriber

Primary Insured Name: _____ Primary Insured DOB: _____

Primarry Insured SSN: _____ Employer: _____

Insurance Company: _____

Plan Name or Coverage Type: _____

Group Name / Number: _____

Contract / Policy Number:: _____

Effective Date: _____

Send Claims to:

Department / ATTN: _____

Mailing Address: _____

City: _____ State: _____ Zipcode: _____

Customer Service/Claims Phone Number: _____

I authorize the Health Planning Council of Southwest Florida the use of the above information for the purposes of obtaining third party / insurance reimbursement on behalf of the insured and the Early Steps program.

_____ _____

Patient/Guardian Signature Date

☐ I verify the information above was obtained directly from the insurance card or other authentic policy document

_____ _____

Early Steps / HPCSWF Representative Signature Date