SPRINGFIELD FAMILY MEDICAL CENTER

123 Medical Plaza Drive • Springfield, IL 62701 • Phone: (555) 123-CARE

INSURANCE VERIFICATION FORM

INSURANCE INFORMATION REQUIRED: Please bring your insurance cards with you today. We will make copies for our records. If you do not have insurance or if your insurance has changed, please inform our staff immediately.

PRIMARY INSURANCE

Insurance Company Name*

Policy/Member ID Number*

Group Number

Subscriber/Policy Holder Name*

Subscriber Date of Birth*

Relationship to Subscriber*

☐ Self ☐ Spouse ☐ Child ☐ Other

SECONDARY INSURANCE (If Applicable)

Insurance Company Name

Policy/Member ID Number

Group Number

Subscriber/Policy Holder Name

Subscriber Date of Birth

Relationship to Subscriber

☐ Self ☐ Spouse ☐ Child ☐ Other

INSURANCE VERIFICATION

For Office Use Only:

Copay Amount

Deductible

Effective Date

Verified By

Date Verified

I certify that the insurance information provided above is accurate and current. I understand that I am financially responsible for any services not covered by my insurance plan.

Patient Signature

Date

*Required fields must be completed

Please present insurance cards for verification