Insurance Payment Tracker

Doctor		**Date**	
Patient #		**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			

Insurance Payment	
Primary Insurance:	**Secondary Insurance:**

Diagnosis & Treatment:

Insurance Company Section

Reasons for pending claim (If applicable); or date and details of claim payments made or expected shortly:

If claim has been denied, the reasons given:

Have patient and/or medical facility been informed about the status?

Other notes and comments

Name & Signature		**Contact details**	