Insurance Information Sheet for Statim Medical Billing

PLEASE COPY THE FRONT AND BACK OF THE INSURANCE CARD

Patient Information	Insured Information
Patient Name:	Insured Name:
Patient Date of Birth:	Insured Date of Birth:
Patient SS#:	Insured SS#:
Patient Address:	Insured Address:
Patient Phone Number:	Insured Phone Number:
Patient Employer:	Insured Employer:
Patient Marital Status: S M	Insured Marital Status: S M
Employed F/T Student P/T Student	Employed F/T Student P/T Student

Relationship to Patient:_____

Primary Insurance:_____

Address for Claims:_____

ID#:_____

Group#:_____

Secondary Insurance Info:_____

ID#:_____

Group#:_____