Insurance Information

PLEASE READ

It is **very important** that we get complete and accurate insurance information. Before we can schedule an appointment at 1 CP Place we must determine if a pre-certification and/or referral from your Primary Care Physician (PCP) is required. Supplying us with a completely legible scan/copy of the **front and back** of all of your insurance cards is preferred, however if that is not possible please fill in this form in its entirety. Any illegible, missing, or inaccurate information will delay our ability to confirm eligibility and in scheduling an appointment.

Patient's Name: _____ Date of Birth: _____

Primary Insurance:

Insurance Company:

Policy Holder's Name: Insurance ID Number:

Policy Holder's Birthdate: Insurance Group Number:

"Providers Call" number (usually on back of card):

Payor Number/ID/EDI (5 digits, usually on back of card):

Secondary Insurance:

Insurance Company:

Policy Holder's Name: Insurance ID Number:

Policy Holder's Birthdate: Insurance Group Number:

"Providers Call" number (usually on back of card):

Payor Number/ID/EDI (5 digits, usually on back of card):

Tertiary Insurance:

Insurance Company:

Policy Holder's Name: Insurance ID Number:

Policy Holder's Birthdate: Insurance Group Number:

"Providers Call" number (usually on back of card):

Payor Number/ID/EDI (5 digits, usually on back of card):