REQUEST FOR VERIFICATION OF BENEFITS

DR. JESSICA FRITZ, DOM

ROOT THERAPIES CHINESE MEDICINE AND HERBAL APOTHECARY, LLC

PATIENT INFORMATION: **APPOINTMENT DATE:**_____

PATIENT NAME:_____ **DOB:**_____

HOME PHONE:_____ WORK/CELL:_____

ADDRESS:_____ **GENDER: MALE FEMALE**

CITY:_____ **STATE:**_____ **ZIP:**_____ **MARRIED: YES NO**

STUDENT / EMPLOYER**:**_____

REFERRING DOCTOR**:**_____ PHONE:_____

SSN (OPTIONAL):_____

INSURANCE INFORMATION:

PRIMARY INSURANCE CARRIER: _____

MEMBER ID #:_____ **GROUP #:**_____

TELEPHONE #:_____

INSURED'S NAME:_____ **INSURED'S DOB:**_____

SECONDARY INSURANCE CARRIER:_____

MEMBER ID #:_____ GROUP #:_____

TELEPHONE #_____

INSURED'S NAME:_____ INSURED'S DOB:_____

W.C. OR AUTO:

INSURANCE CARRIER:_____

CLAIM #**:**_____ DATE OF INJURY**:**_____

ADJUSTER**:**_____ PHONE #:_____