

Health care information is personal and sensitive information related to a person's healthcare. It is being faxed to you after appropriate authorization from the patient or under circumstances that don't require patient authorization. You, the recipient, are obliged to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

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 #:** _____