



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name of Insurance: \_\_\_\_\_ Type: HMO/PPO/POS/EPO

Subscriber or I.D. # \_\_\_\_\_ Group# \_\_\_\_\_

Customer/Provider Tel. # \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Notes: Effective Date: \_\_\_\_\_

Co-Pay: \$ \_\_\_\_\_

Deductible: \$ \_\_\_\_\_ Met: \$ \_\_\_\_\_

Out of Pocket: \$ \_\_\_\_\_ Met: \$ \_\_\_\_\_

Co-Insurance: \_\_\_\_\_

Pre-Cert/Prior Auth: \_\_\_\_\_ Auth # \_\_\_\_\_

Address: \_\_\_\_\_

Direct Line Tel #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Reference # \_\_\_\_\_

**UFE**

**MRI**

**ELVS/Phlebectomy**

Need Auth ?:

Need Auth ?:

Need Auth?: