## Liz NewmanWellness

INSURA	NCE VERIFICATION Date
Last Name,	First Name
Patient Phone #:	
Patient Date of Birth:	Male: Female:
Patient, Subscriber # / ID #:	
Group #:	
Insured Name & ID# (if Differen	nt from patient)
Relationship to Insured:Se	elfSpouseChildOther
Insurance Co Name:	
Ins. Co. Phone #:	
Chief Complaint or Primary Dia	gnosis:
Claim # if an accident:	
Date of Accident/ Injury:	
Other Info:	
To be completed by office staff:	Date Verified:
Effective Date:	Spoke To:
Deductible \$ Amo	ount met \$
	s % allowed rovider type
PT Yes / No # of Visits	% allowed
Office Visit Yes / No	

Insurance Company Address:\_\_\_\_\_