# INSURANCE CLAIM REQUEST

# [WE WILL SEND IT TO YOUR INSURANCE ELECTRONICALLY]

PATIENT NAME:_______________________________________

PATIENT ADDRESS:______________________________________________________________________

______________________________________________________________________________

PATIENT DATE OF BIRTH:__________________________________

**POLICY/INSURANCE MEMBER NAME** :FIRST:__________________________________

LAST:____________________________________

**POLICY/INSURANCE MEMBER EMPLOYER/GROUP NAME**: ___________________________________

**POLICY/INS MEMBER ADDRESS: _________________________________**

**__________________________________________________________________**

**POLICY HOLDERS DATE OF BIRTH**: _______________

**POLICYHOLDERS SSN: ______________________**

**POLICY HOLDER ID #:________________________________**

**GROUP NUMBER:____________________**

**INSURANCE COMPANY NAME: ____________________________**

**INSURANCE CLAIM ADDRESS[USUALLY ON BACK OF CARD]:**

**____________________________________________**

**____________________________________________**