



INSURANCE VERIFICATION FORM

To serve you best and to ensure insurance benefit information is available for your visit, PLEASE RETURN THIS COMPLETED FORM 5 DAYS PRIOR TO YOUR APPOINTMENT.

Via: E-mail Billing@DrLawrence.com; Fax (440) 974-0305 or by Mail.

Pretreatment information from your insurance company is not always reliable. Please contact your insurance company to verify information the insurance company provides our office.

MEDICAL INSURANCE INFORMATION

Patient Name _____ Patient DOB ____/____/____

Subscriber Name _____ Subscriber DOB ____/____/____

Subscriber SSN # _____ - _____ - _____ Subscriber ID # _____

Insured Person: Mother Step-Mother Father Step-Father Self Spouse

Employer _____

Insurance Company _____

Claims Mailing Address _____

Insurance Co. Phone # _____

Group # _____ Payer ID _____

**If you have a second insurance, please fill out a form for each*

OFFICE USE ONLY

_____ PRIMARY INSURANCE _____ SECONDARY INSURANCE

Ortho _____% Max \$ _____ Used \$ _____ Remaining \$ _____

Deduct _____ MET - YES NO Age Limit _____ Student Age _____

Effective Date _____ Bill - Monthly Quarterly Automated Yes No

TMD Coverage YES NO \$ _____

Waiting Period Yes No Pay In Progress Yes No Assignment Yes No

Verified By _____ Rep _____ Date ____/____/____