

Patient Face Sheet

The following information is required to bill your insurance company.

Patient Name: _____ DOB: _____
Address: _____ Sex: _____
City, State, Zip: _____ SSN: _____
Home Phone: _____ Mar Status: _____
Cell Phone: _____ Work Phone: _____

Your Employer Name: _____
Address: _____
City State, Zip _____

Case Information

Physician Name, City, State: _____
A Physician you have seen in the past 12 months.

Primary Insurance to be Billed:

Policy Number: _____
Group Number: _____
Address: _____
City, State, Zip: _____
Phone: _____

Secondary Insurance to be Billed:

Policy Number: _____
Group Number: _____
Address: _____
City, State, Zip: _____
Phone: _____

Office Use Only: *If no RX on hand, list ICD-9 codes you would like to request from PCP.*

RX ICD-9 CODES: _____
Auth # Visits: _____ RX Date: _____

fax to:
332-1696