# verification of eligibility

**Patient**

| Name (Last, First) | Age | Birth Date | Sex | |
|---|---|---|---|---|
| Mailing Address | City | State | Zip Code | Marital Status |
| Primary Diagnosis | Primary Numeric Diagnosis | Secondary Numeric Diagnosis | | |

**Responsible Party (Insurance only skip section if Medicaid or Medwaiver)**

| Name (Last, First) | Age | Birth Date | Sex | Relationship to Patient |
|---|---|---|---|---|
| Address (put same if same as above) | City | State | Zip Code | Marital Status |
| Employer | Home Phone | Cell Phone | | |

**Referring Provider**

| Name (Last, First) | Phone | Fax |
|---|---|---|

**Primary Insurance Information**

| Primary Insurance Company | Policy Holder Name | | Date of Birth | Policy Number |
|---|---|---|---|---|
| Insurance Address | City | State | Zip Code | Group Number |
| Phone Number | Co-Insurance % | | Co-Pay | Deductible |

**Secondary Insurance Information**

| Secondary Insurance Company | Policy Holder Name | | Date of Birth | Policy Number |
|---|---|---|---|---|
| Insurance Address | City | State | Zip Code | Group Number |
| Phone Number | Co-Insurance % | | Co-Pay | Deductible |