Debbie Webb INSURANCE VERIFICATION & PRE-AUTH. FORM: CONFIDENTIAL

Name: _____

Date: ____/____/_____ **Date of Birth:** ____/____/_____

Insurance Company: _____

Insurance Co. Phone #: _____

Type of Policy: _____

Member ID #: _____

Group Number: _____

Is this Person Primary Member on Insurance? Yes No

If NO, Name and DOB of who is primary member: _____

_____

Do you have a supplemental / secondary insurance policy? Yes No

If YES, name, phone number and policy info is? _____

_____

Member Address: _____

Member Phone #:_____

Member email:_____

Other comments:

Please submit this form to debbiewebb@aol.com or scan and fax it to Dr. Debbie Webb at (737) 255-9744. Also include a photo of the front and back of your insurance card(s). Thank you!