

**Insurance Eligibility Form**  
**Phone (916)978-0300 Fax (916)978-0333**

**Program:**

*Please return this form by fax, attach a copy of the front & back of your insurance card if possible*

Patient Name: \_\_\_\_\_ Patient SS #: \_\_\_\_\_

Home Phone#: \_\_\_\_\_ Cell Phone#: \_\_\_\_\_

Patient DOB: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Subscriber DOB: \_\_\_\_\_ Subscriber SS# \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Insurance Co. Phone #: \_\_\_\_\_

Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Available Benefits: \*\*\*\* FOR OFFICE USE ONLY \*\*\*\***

Effective Date: \_\_\_\_\_ Type of Coverage/Plan: \_\_\_\_\_

OTC Contracted: Yes [ ] No [ ] Out of Network Benefits: Yes [ ] No [ ]

Amount of deductible: \_\_\_\_\_ Amount met: \$ \_\_\_\_\_

Amount owed: \_\_\_\_\_ Amount of Co-Pay: \$ \_\_\_\_\_

**Plan Allows:** Initial Physical \_\_\_\_\_ Ongoing Office Visits \_\_\_\_\_  
Diagnostic Tests \_\_\_\_\_ Nutritional Food Products \_\_\_\_\_

Verify Billing Address: \_\_\_\_\_

Exclusions: \_\_\_\_\_

Date: \_\_\_\_\_ Spoke With: \_\_\_\_\_



Initials: \_\_\_\_\_