

A Sober Way Home
Insurance Verification

1) Patient Name: _____ Male ____ Female ____

2) Patient Address: _____

3) Patient Phone: _____

4) Patient Social Security #: _____

5) Patient Date of Birth: _____

Employed: Yes ____ No ____ Student: Yes ____ No ____

6) Insured Name: _____

7) Insured Social Security #: _____

8) Insured Date of Birth: _____

9) Insured's relationship to Patient: _____

10) Insured's employer: _____

11) Insurance Company: _____

12) Insurance Phone Number: _____

13) ID #: _____

14) Group #: _____

15) Type of Plan: _____

16) Reference: _____

Please Fax to: 928-778-1726

