

Insurance Confirmation Form

Patient Name: _____

Primary Insurance

Insurance Provider: _____

Policy Holder: _____

Coverage

\$ _____, _____ %

Amount Available: \$ _____

Age limit: _____

Is Direct Billing allowed? Yes No

Secondary Insurance

Insurance Provider: _____

Policy Holder: _____

Coverage

\$ _____, _____ %

Amount Available: \$ _____

Age limit: _____

Is Direct Billing allowed? Yes No