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