

**CLIENT INFORMATION – PART IV – INSURANCE FILING INFO**

**(Please fill this out even if you are planning to submit claims yourself. This information allows me to follow up with any reimbursement problems. Thank you.)**

Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_

SS#: \_\_\_\_\_

Policy Holders: \_\_\_\_\_ DOB: \_\_\_\_\_

SS#: \_\_\_\_\_

Insurance Type (circle one or fill in other blank):

CHAMPUS CHAMPUSVA FECA MEDICAID MEDICARE Group

Other: \_\_\_\_\_

Circle one: HMO PPO Other: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Claim Mailing Address: \_\_\_\_\_

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

Plan Name: \_\_\_\_\_

ID#: \_\_\_\_\_ Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

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Secondary Policy? Yes No (If yes, fill out below)

Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Employer: \_\_\_\_\_

Plan Name: \_\_\_\_\_