coppell wellness center

# INSURANCE VERIFICATION REQUEST

Patient's Name ______________________________

Name of Insured ______________________________

(Relationship) ______________________________

Patient's Date of Birth ______________________________

Address ______________________________

City / ST/ Zip ______________________________

Contact Phone Number ______________________________

______________________________

Insurance Company Name ______________________________

Insurance Phone Number ______________________________

Group Number ______________________________

Insured ID /Member Number

***Please note that the benefits quoted to us by your insurance company are not a guarantee of payment. We will file your claim and await payment for 90 days. If your insurance company pays the benefits they quote to us, the only services you will be responsible for are any non-covered services, deductibles or co-pays.***