# Tavernier Wellness Center, Inc.
# Stefanie Woods, A.P.

**INSURANCE VERIFICATION** **Date**__________

Patient Name: ________________________________________
Last Name, First Name

Patient Address: ______________________________________

City, State & Zip(Must Have) ______________________________

Patient Phone #: ______________________________________

Patient Date of Birth: _________________ Male: ____ Female: _____

Patient, Subscriber # / ID #: _________________________________

Group #: __________________________________________

Insured Name & ID# (if Different from patient) ____________________

Relationship to Insured:_____Self_____Spouse_____Child_____Other_____

Insurance Co Name: ____________________________________

Ins. Co. Phone #: ____________________________________

Claim # if an accident: ____________________________________

Date of Accident/ Injury: ___________________________________

Other Info: ____________________________________

**To be completed by office staff:** **Date Verified:**______________

Effective Date: _________________ Spoke To: _______________

Deductible $ ________ Amount met $ _________

Acupuncture Yes / No # of Visits ______ % allowed __________

Office Visit Yes / No

PT Yes / No # of Visits ______ % allowed ___________

Insurance Company Address: ______________________________

______________________________