ENCLAVE
FAMILY HEALTHCARE

Verification of Benefits

Patients Name:

*DOB:*_____ *SSN:*_____

*Place of Employment:*_____

Home Address:

Phone: Home: Cell: _____

Policy Holder's Name:_____

*DOB:*_____ *SSN:*_____

*Place of Employment:*_____

Primary Insurance Company: *(if you do not have insurance and will pay for your services, please write "self pay" in the blank and skip to signature)*

Insurance Phone: _____ *Members ID:* _____

Effective Date: *Copay: $*_____

Family Deductible: $ *Amount met: $*

Individual Deductible: $ *Amount met: $*

Max Out of Pocket: $ *Amount met: $*

Secondary Insurance Company: _

Insurance Phone: _____ *Members ID:* _

Effective Date: *Copay: $*_____

Family Deductible: $ *Amount met: $*

Individual Deductible: $ *Amount met: $*

Max Out of Pocket: $ *Amount met: $*

Person Responsible for Payment on this Account: _____

Address: _____ City, State, Zip: _____

Phone: Home: _____ Cell: _____

Signature: _____ **Date:** _____

Please provide your insurance card(s). This will allow us to file your claim with your insurance carrier(s).

Once payment is received from your insurance carrier(s) you will be billed for any required copayments, coinsurance and/or deductible amounts not paid at the time of service.

Thank you in advance for your cooperation and assistance in assuring you receive the benefits allowed by your insurance carrier.