

# INSURANCE VERIFICATION

UCSF Comprehensive Cancer Center

PATIENT NAME: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

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

Please attach a copy of your insurance card (front and back) and return with this form by mail or fax.

## TYPE OF INSURANCE

PPO    HMO    EPO    POS TIER 1    POS TIER 2    OTHER \_\_\_\_\_

\*IF HMO, need authorization for visits and testing\*

PLEASE ANSWER THE FOLLOWING QUESTIONS:

INSURANCE CARRIER:  SELF OR  SPOUSE

SUBSCRIBER NAME: \_\_\_\_\_

\*Subscriber is the policyholder or person who obtained health insurance.

SUBSCRIBER SOCIAL SECURITY NUMBER: \_\_\_\_\_

SUBSCRIBER DATE OF BIRTH: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

EMPLOYMENT STATUS:  FULL TIME    PART TIME    RETIRED

POLICY NUMBER: \_\_\_\_\_

OFFICE VISIT COPAY: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_

PHONE NUMBER for MEMBER SERVICE OR CUSTOMER SERVICE: \_\_\_\_\_

(Sometimes on insurance card.)

INSURANCE ADDRESS OR P.O. BOX: \_\_\_\_\_

CLAIMS NUMBER (Insurance Company): \_\_\_\_\_

## REFERRING PHYSICIAN AND PRIMARY CARE INFORMATION

NAME OF REFERRING PHYSICIAN: \_\_\_\_\_

REFERRING PHYSICIAN CONTACT: \_\_\_\_\_

NAME OF PRIMARY CARE PHYSICIAN (PCP): \_\_\_\_\_

(PCP) CONTACT NUMBER: \_\_\_\_\_

NAME OF MEDICAL GROUP: \_\_\_\_\_