IMPORTANT! Items in **BOLD** are required to process your claims. Failure to provide this information could lead to the denial of benefits.

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ MI: _____

Address: _____ **Sex:** Male Female

City: _____ **State:** _____ **Zip:** _____ Student: No Part Time Full Time

Social Security #: _____ **Date of Birth:** _____

Home Phone: _____ Cell Phone: _____

Work Related*: Yes ☐ No ☐ **If Yes, date of injury?** _____

*If work related, the following information **MUST** be completed to process your claim.

Employed: Full Time Part Time No Retired

Employer: _____ Drivers License #: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____ **Work Phone:** _____

Position:

PRIMARY INSURANCE INFORMATION

Ins. Company: _____ **Ins. Phone Number:** _____

Ins. Claims Address: _____

Member ID #: _____ Effective Date: _____

Group Name: _____ Group ID #: _____

Type of Plan: _____ (i.e. HMO) Deductible: _____ Co-Pay: 10 15 20 25 35

Name of Insured: _____ **Insured's DOB:** _____

Insured's Address: _____

Relationship to Insured:

SECONDARY INSURANCE INFORMATION (if applicable)

Ins. Company: _____ Ins. Phone Number: _____

Ins. Claims Address: _____

Member ID #: Effective Date:

Name of Insured: Relationship to Insured:

In case of emergency notify: _____ **Phone:** _____

I understand that I am responsible for all charges incurred by me and all charges not allowed by my insurance company. I authorize release of any medical information necessary to process my claims. I authorize payment of any assigned benefits to Back To Action, 1118 E. Harrison, Harlingen, TX 78550.

_____ _____

Signature Date

OFFICE STAFF ONLY

REFERRING PHYSICIAN: _____ **UPIN #:** _____

DIAGNOSIS: WC FILE #:

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