

**INSURANCE VERIFICATION**

Aesthetic and Anti-Aging Medicine Center  
1132 Hillcrest Rd • Mobile, Al 36695  
251-776-1380

PATIENT'S NAME: _____ DOB: _____ PHONE #: _____ TODAY'S DATE: _____
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**INSURANCE CARRIER (PRIMARY):** \_\_\_\_\_

CONTRACT #: \_\_\_\_\_ GROUP#: \_\_\_\_\_

EFFECTIVE COVERAGE DATE: \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_ DOB: \_\_\_\_\_

PATIENT'S RELATIONSHIP TO INSURED: *PLEASE CIRCLE BELOW*

SELF                      SPOUSE                      CHILD                      OTHER \_\_\_\_\_

**INSURANCE CARRIER (SECONDARY):** \_\_\_\_\_

CONTRACT #: \_\_\_\_\_ GROUP#: \_\_\_\_\_

EFFECTIVE COVERAGE DATE: \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_ DOB: \_\_\_\_\_

PATIENT'S RELATIONSHIP TO INSURED: *PLEASE CIRCLE BELOW*

SELF                      SPOUSE                      CHILD                      OTHER \_\_\_\_\_

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*OFFICE ADMINSTATION USE ONLY*

# 1 INSURANCE EFFECTIVE DATE: \_\_\_\_\_

COPAY \_\_\_\_\_

DEDUCTIBLE \_\_\_\_\_

BENEFITS: \_\_\_\_\_

# 2 INSURANCE EFFECTIVE DATE: \_\_\_\_\_

COPAY \_\_\_\_\_

DEDUCTIBLE \_\_\_\_\_

BENEFITS: \_\_\_\_\_