Special Return instructions back to Facility: _____

Preferred method of submission – email to: dataentry@medprobill.com

7 SUMMIT PATHWAYS / The Wellness Group of Tampa

INSURANCE VERIFICATION FORM

NORMAL BUSINESS HOURS: PLEASE COMPLETE THE BOXED PORTION ONLY AND FAX TO **1-877-396-3853**

AFTER 5:00 PM: CALL 1-800-990-0340 (NOTIFY AFTER-HOUR SPECIALILST, COMPLETE THE BOXED PORTION, FAX TO **1-877-396-3853**)

*PATIENT NAME:*_____ *DOB:* _____ *SEX:* M F

PATIENT ADDRESS: _____ *PATIENT PHONE:* _____

SUBSCRIBER NAME: _____ *SUB. DOB:*_____

SUBSCRIBER REL: _____ *EMPLOYER:*_____ *EMPLOYED:* Y N *STUDENT:* Y N

INSURANCE CO: _____ *INS. PHONE #:*_____

ID # _____ *GROUP #*_____ *TYPE OF PLAN* _____ *REF*_____

FACILITY REPRESENTATIVE: _____ *DATE:* _____ *TIME:* _____