# Additional Insurance Provider

Insurance Company: _____ Policy Number: _____

Group Number: _____ Plan Number: _____

Address: _____ Phone Number: _____

_____ Fax Number: _____

Contact Person: _____ Policy Effective Date: _____

Employer Contact: _____

Name of Employer: _____

Address of Employer: _____ Employer Phone: _____

_____

Deductible: _____

Primary Care Physician: _____

Address: _____ Phone Number: _____

_____

# Additional Insurance Provider: Covered Services

| Services | Percent Covered | Co-Pay |
|---|---|---|
| Physician Office Visit | | |
| Hospitalization | | |
| Emergency Room Visit | | |
| Urgent Care Visit | | |
| Durable Medical Equipment | | |
| Prescriptions | | |
| Home Care | | |
| Speech Therapy | | |
| Occupational Therapy | | |
| Physical Therapy | | |
| Ambulance Services | | |
| Inpatient Mental Health Services | | |
| Outpatient Mental Health Services | | |
| Other | | |