Primary 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: _____

_____

Primary 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		