

PATIENT & INSURANCE DATA

INFORMATION NEEDED FOR COMPLETING HCFA-1500 CLAIM FORMS

PATIENT INFORMATION

NAME: _____

ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

PHONE: H _____ W _____

DATE OF BIRTH: _____ AGE _____

CURRENT EMPLOYER: (if WC)

ADDRESS: _____

PHONE: _____

WORK COMP CASES: EMPLOYER AT TIME OF INJURY: _____

ADDRESS: _____

CITY _____ PHONE _____

SEX: MALE : FEMALE: (**CHECK BOX**)

STATUS: SINGLE : MARRIED: SEPARATED:
 DIVORCED: WIDOWED: OTHER:
EMPLOYED: FULL TIME: PART TIME:
 RETIRED: UNKNOWN: NON-EMPLOYED:
F/T STUDENT: **P/T STUDENT:**
CONDITION IS RELATED TO:

 EMPLOYMENT: AUTO ACCIDENT: OTHER:
STATE OF OCCURRENCE:

 GRADUAL: **FIRST DR. APPT:**

 OR INJURY: **DATE OF INJURY:**

 ANY DATES UNABLE TO WORK?
 FROM ____/____/____ TO ____/____/____

EMERGENCY ROOM VISIT? DATE ____/____/____

 HOSPITALIZATION?
 FROM ____/____/____ TO ____/____/____

PRESCRIBING PHYSICIAN:(incl.credentials, eg "MD"
 DO, DC)

OF VISITS PRESCRIBED BY DR.:

_____ times _____ per week

DIAGNOSES _____

INSURANCE INFORMATION

 PATIENT'S RELATION TO INSURED:
 ___SELF ___SPOUSE ___CHILD ___OTHER

NAME OF INSURED (if different than patient)

DOB ____/____/____

ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

INSURANCE CO: _____

PLAN NAME: _____

CLAIMS OFFICE

ADDRESS: _____

CITY _____ STATE: _____ ZIP: _____

CLAIM OR CASE #: _____

INSURED'S ID #: _____

POLICY/GROUP #: _____

ADJUSTER: _____

PHONE: _____

**PAYMENT WILL BE EXPECTED AT
EACH VISIT UNLESS OTHER
ARRANGEMENTS HAVE BEEN MADE**

PLEASE CHECK ONE: CASH: _____

CHECK: _____ CREDIT CARD: _____

OTHER _____

CREDIT CARD TYPE: _____

CARD #: _____

EXP. DATE: _____

AUTO INS: _____ ATTORNEY LIEN: _____

WORKERS' COMP. INS: _____

MAJOR MED: _____

**IF CASE IN LITIGATION,
ATTORNEY:** _____

ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

PHONE: _____

**IN AN EMERGENCY
CONTACT**

PHONE
