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 #_____