Flourish, LLC

INSURANCE BILLING INFORMATION

Today's Date:_____
Patient Name:_____
Address:_____
City:_____State:_____Zip_____
Date of Birth:____/____/____ F____ M____
Social Security#_____-_____-_____

Patient Relationship to insured:
Self_____ Spouse_____ Child_____ Other_____
Group Plan or Program:_____
Insurance Company:_____
Insured's ID Number:_____
Insured's Policy Group Number:_____
Address:_____
City:_____State:_____Zip_____

If the insured is different from above patient:
Insured's Name:_____
Insured's Address:_____
City:_____State:_____Zip_____
Insured's Date of Birth:_____/_____/_____ F_____ M_____

Is patient's condition related to:
Employment? Yes_____ No_____
Auto accident? Yes_____ No_____
Other accident? Yes_____ No_____

If Accidental Injury:
Accident or injury date:_____/_____/_____
State where accident took place:_____
Claim number:_____