PLAZA VISION CENTER
ADVANCED EYE CARE SPECIALISTS

Insurance Verification Form

To insure that we know about all of your insurance, please take a moment to complete the following information. We need to verify all of your insurance information prior to your visit. The requested information on this form can be found on the front and the back of your insurance card. To complete this form, press the "Tab" key to move to the next field.

YOUR MEDICAL HEALTH INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE	
Name of Patient	
Name of Insured	
Relation to Patient	☐ Self ☐ Spouse ☐ Partner ☐ Other:
Insurance Company	☐ BC/BS PPO ☐ United HealthCare ☐ CIGNA HMO ☐ Humana ☐ PHCS ☐ Aetna ☐ True-Choice ☐ Medicare ☐ Medicaid
Plan Group Number	
Member Identification Number	
Verification Telephone Number	
SECONDARY MEDICAL INSURNACE	
Name of Patient	
Name of Insured	
Relation to Patient	☐ Self ☐ Spouse ☐ Partner ☐ Other:
Insurance Company	☐ BC/BS PPO ☐ United HealthCare ☐ CIGNA HMO ☐ Humana ☐ PHCS ☐ Aetna ☐ True-Choice ☐ Medicare ☐ Medicaid
Plan Group Number	
Member Identification Number	
Verification Telephone Number	

YOUR VISION INSURANCE INFORMATION

Name of Patient							
Name of Insured							
Relation to Patient	☐ Self ☐ Spouse ☐ Partner ☐ Other:						
Insurance Company	☐ Vision Service Plan ☐ Eye-Med ☐ Vision Benefits of America ☐ Vision Care Plan of America						
Plan Group Number							
Insured's Social Security Number							
Insured's Date of Birth	Month		Day		Year		

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