Insurance Information Form

Required at time of Clinic Administration

For some insurance plans this will be processed by your prescription plan, for others it will be covered by your medical plan. Both will be collected at this time to ensure accurate process completion.

Participant Name: First______________Last_______________________

Date of Birth ____________________

If over 65 or on Medicare, your Medicare part A/B # _________________

Prescription Plan information:

Name of Plan ____

Bin # ____

PCN # ____

Group # ____

ID # ____

Relationship circle one: Primary Spouse Child

If not Primary, please provide primary insurer's name: ________________

Medical Plan information:

Name of Plan ____

Group # ____

ID # ____

Processor control # if on card ________________________________

Relationship circle one: Primary Spouse Child

If not Primary, please provide primary insurer's name: ________________

If it is a COVID dose and patient does not have insurance, please document patient's driver's license # if available. **Driver's License #**__________________________