

## Insurance Benefits

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Insured's Name** \_\_\_\_\_

**Carrier** \_\_\_\_\_

**Insurance phone #** \_\_\_\_\_

**Group #** \_\_\_\_\_

**Insured SS #** \_\_\_\_\_

**Patient's SS#** \_\_\_\_\_

**Patient's Birth date** \_\_\_\_\_

**Insured's Birth date** \_\_\_\_\_

**Coverage anniversary date** \_\_\_\_\_

**Annual Maximum** \_\_\_\_\_

**Remaining Benefits** \_\_\_\_\_