Dr. Colquitt, FACS, FASMBS
Dr. Ray, FACS, FASMBS
P 865-984-3413
F 865-212-5597

Foothills Weightloss Specialists Insurance Verification Form

Patient Information

Name _____

SSN _____ DOB _____

Male _____ Female _____

Address _____

_____

City _____ Referral Source _____

State _____ Zip _____ Primary Care MD _____

Home Ph _____

Cell Ph _____

Email _____

Insurance Information

Subscriber Name _____ Subscriber DOB _____

Subscriber SSN _____ _____

Relationship to Subscriber (self, child, spouse or other) _____

Insurance Name _____

Policy # _____ Group # _____

Insurance phone # _____

Employer Name _____

Secondary Insurance Information (if applicable)

Subscriber Name _____ Subscriber DOB _____

Insurance Name _____

Policy # _____ Group # _____

Insurance phone # _____

I authorize Premier Surgical Associates and Foothills Weightloss Specialists to verify my insurance benefits on my behalf. I know that I am ultimately responsible for obtaining and understanding all of my insurance benefits.

Sign _____ Date _____