

# HEATHROW URGENT CARE

The Quality Of Care You Deserve

## INSURANCE VERIFICATION FORM

*This information is only required if you are a new patient or if your insurance information has changed since your last visit.*

Patient Name: \_\_\_\_\_ (Last) \_\_\_\_\_ (First)  
Patient D.O.B. (mm/dd/yy): \_\_\_\_\_  
Primary insured name: \_\_\_\_\_ (Last) \_\_\_\_\_ (First)  
Primary insured D.O.B. (mm/dd/yy): \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_  
Insurance Provider: \_\_\_\_\_  
Policy number: \_\_\_\_\_  
Group Number: \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
(if policy # is same as SSN) \_\_\_\_\_  
Insurance customer service number: \_\_\_\_\_

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