INSURANCE VERIFICATION

UCSF Comprehensive Cancer Center

PATIENT NAME: _____

Date of Birth: _____

Social Security Number: _____

Insurance: _____

Please attach a copy of your insurance card (front and back) and return with this form by mail or fax.

TYPE OF INSURANCE

□ PPO □ HMO □ EPO □ POS TIER 1 □ POS TIER 2 □ OTHER_____

IF HMO, need authorization for visits and testing

PLEASE ANSWER THE FOLLOWING QUESTIONS:

INSURANCE CARRIER: □ SELF OR □ SPOUSE

SUBSCRIBER NAME: _____
*Subscriber is the policyholder or person who obtained health insurance.

SUBSCRIBER SOCIAL SECURITY NUMBER: _____

SUBSCRIBER DATE OF BIRTH: _____

EMPLOYER:_____

EMPLOYMENT STATUS: □ FULL TIME □ PART TIME □ RETIRED

POLICY NUMBER: _____

OFFICE VISIT COPAY: _____

GROUP NUMBER: _____

PHONE NUMBER for MEMBER SERVICE OR CUSTOMER SERVICE: _____
(Sometimes on insurance card.)

INSURANCE ADDRESS OR P.O. BOX: _____

CLAIMS NUMBER (Insurance Company): _____

REFERRING PHYSICIAN AND PRIMARY CARE INFORMATION

NAME OF REFERRING PHYSICIAN: _____

REFERRING PHYSICIAN CONTACT: _____

NAME OF PRIMARY CARE PHYSICIAN (PCP): _____

(PCP) CONTACT NUMBER: _____

NAME OF MEDICAL GROUP: _____