

## Insurance Billing Information

(Please complete as much information as possible. \* Must have. Your debt depends on this.)

**Name** \_\_\_\_\_ **SS#** \_\_\_\_\_  
Last First Middle Int.

**\*Address** \_\_\_\_\_ **\*Home Phone** \_\_\_\_\_  
\_\_\_\_\_ **\*Work Phone** \_\_\_\_\_  
\_\_\_\_\_ **\*Birth Date** \_\_\_\_\_

Single Y N **\*Condition Related to?**  
Married Y N Employment Y N  
Other \_\_\_\_\_ Auto Accident Y N  
State \_\_\_\_\_ Date \_\_\_\_\_  
Drivers License \_\_\_\_\_ Other Accident \_\_\_\_\_

**\*Insured ID Number** \_\_\_\_\_ **Policy #** \_\_\_\_\_  
**\*Adjusters Name** \_\_\_\_\_ **Claim #** \_\_\_\_\_  
**\*Billing Address** \_\_\_\_\_ **Ph #** \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_

**Employers Name** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**\*Referring Physician** \_\_\_\_\_ **\*Phone #** \_\_\_\_\_

**Prescription** Y N **Self Referred** Y N  
(Must have for MVA) (Must have pre-authorization)

Please describe what happened:

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I understand that it is my responsibility for any and all expenses regardless of any other type of arrangements that may or may not have been made or agreed upon. Angelic Healing Hands, Inc. is providing billing services as a courtesy to me and does not guarantee benefits or coverage from my insurance provider. (Pre-authorization is recommended)

**\*Client Signature** \_\_\_\_\_ **\*Date** \_\_\_\_\_