ADVANCED INTEGRATIVE MEDICINE

Insurance Form*

Patient's Name (as it appears on card): ______________________________

DOB of Subscriber: _____________

Driver's License #: __________________ SS#: ___________________

Ins. Co. Name: ______________________ Ins. Customer Service #: ________________

Provider Phone #: ________________ ID#: ________________

Group #: ________________ Ins. Plan Type: Employee Self Family

Primary Address to Send Claims: ____

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Signature: _______________________________ Date: __________________

Please send copy of ID and Insurance card to: kgfcandpt@aol.com