Thrive
Therapy Associates, LLC

Insurance Information Form

Today's Date: _____

Patient Name: _____

Patient DOB: _____

Patient's Relationship to Insured:_____

Insured's ID Number:_____

Referring Physician:_____

Primary Insured Name:_____

Primary Insured Address:_____
(if different than patient)
Primary Insured Phone Number:_____
(if different than patient)

Primary Insured DOB:_____

Insurance Company: _____

Policy Group or FECA Number:_____

Primary Insured Employers Name:_____

Name - Insurance Plan or Program:_____

Insurance Provider Plan Phone #:_____

Another Ins. Plan/Secondary Insurance: _____
(Yes or No)