FAXED: YES/ NO

***Fill out top half and mail/ or FAX to 262-679-4560 ** Include Copy of Insurance Card If Possible***

## INSURANCE BENEFITS

**DATE:** ____________ **THERAPIST NAME:** ____________________________

**PATIENT NAME:** ______________________________ **DOB** ____________________________

**ADDRESS:** ____________________________________________________________

**INSURED NAME:** ______________________________ **DOB** ____________________________

**INSURED SS#:** ______________________________ **ID #** ____________________________

**GROUP #/EMPLOYER NAME:** ______________________________________________

**NAME OF INSURANCE COMPANY:** ______________________________________________

**ADDRESS:** ______________________________________________

______________________________________________

**PHONE #:** ______________________________________________

**This is not a guarantee of benefits. Please call your insurance carrier to check your benefits. Thanks**