J.L. Walston & Associates

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Insurance Inquiry

General Information-

D.O.S.: _____ New info: ___ Refile: ___ Same Ins, New info: ___
Primary ____ Secondary ____ Tertiary(3rd) ____Work Comp ____ Medicaid ____

Patient Information-

CRS Reference #: _____ Pre Cert. #: _____
Patient's Name: _____ Patient D.O.B.: _____
Relation: self spouse child other_____

Insurance Information-

Insurance Name: _____ Eff. Date: _____
Insured's Name: _____ Insured SSN: _____-____-_____
Insured's D.O.B.: _____ Policy Type: PPN ___ PPO ___ HMO __ PCP ___ POS ___
If Medicare does patient have: A ___ B ___ A&B ___
Policy #: _____ Group #: _____

Claims Address: _____

_____

Phone: ( ) - Ext.

Worker's Comp Information-

Date of Injury: _____ Type of Injury: _____
Employer's Name: _____ Emp phone: ( ) -
WCP Name: _____

WCP Address: _____

_____

WCP Phone: ( ) - Ext.
Contact Person: _____ Claim #: _____

Tricare (Champus)- Circle One – Tricare Prime / Tricare for Life / Tricare Standard

Active Duty Retired Dependent Child
Branch of Service: _____ Rank: _____
Base (if active): _____ Phone: ( ) -
Sponsor's Name _____
Sponsor's SSN: _____-____-_____

"This is an attempt to collect a debt. Any information obtained will be used for that purpose."