

**IMPORTANT!** Items in **BOLD** are required to process your claims. Failure to provide this information could lead to the denial of benefits.

### PATIENT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Address: \_\_\_\_\_ Sex: Male Female  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Student: No Part Time Full Time  
Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Related\*: Yes  No  If Yes, date of injury? \_\_\_\_\_

\*If work related, the following information **MUST** be completed to process your claim.

Employed: Full Time Part Time No Retired  
Employer: \_\_\_\_\_ Drivers License #: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Position: \_\_\_\_\_

### PRIMARY INSURANCE INFORMATION

Ins. Company: \_\_\_\_\_ Ins. Phone Number: \_\_\_\_\_  
Ins. Claims Address: \_\_\_\_\_  
Member ID #: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Group Name: \_\_\_\_\_ Group ID #: \_\_\_\_\_  
Type of Plan: \_\_\_\_\_ (i.e. HMO) Deductible: \_\_\_\_\_ Co-Pay: 10 15 20 25 35  
Name of Insured: \_\_\_\_\_ Insured's DOB: \_\_\_\_\_  
Insured's Address: \_\_\_\_\_  
Relationship to Insured: \_\_\_\_\_

### SECONDARY INSURANCE INFORMATION (if applicable)

Ins. Company: \_\_\_\_\_ Ins. Phone Number: \_\_\_\_\_  
Ins. Claims Address: \_\_\_\_\_  
Member ID #: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

**In case of emergency notify:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

I understand that I am responsible for all charges incurred by me and all charges not allowed by my insurance company. I authorize release of any medical information necessary to process my claims. I authorize payment of any assigned benefits to Back To Action.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### OFFICE STAFF ONLY

REFERRING PHYSICIAN: \_\_\_\_\_ UPIN #: \_\_\_\_\_  
DIAGNOSIS: \_\_\_\_\_ NPI #: \_\_\_\_\_