Dr. NAME
ADDRESS

INTAKE FORM

Acct # _____ Date:_____

Patient Name: _____

Date of Birth: _____ SSN #: _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone # _____ Work Phone # _____

Primary Insurance Name: _____

Member Id # : _____ Group #: _____

Insurance Phone # :_____ Effective Date: _____

Secondary Insurance Name: _____

Member Id # : _____ Group #: _____

Insurance Phone # :_____ Effective Date: _____

PRIOR AUTHORIZATION REQUEST FORM

For Doctor's Office use only :

Treatment Plan:

For Billing Office use only

Current Dx: _____

CPT Code : _____

Insurance Rep Name : _____, Ref # _____

Copay: _____ Innetwork Ded _____Met _____ Out of Network Ded _____ Met_____

Note: Fax the Intake form 48 hours prior to visit so that we can return back to you with the authorization details 24 hours prior to appointment - Fax # 732-404-1556, Attn: Authorization Dept