

**SUBURBAN WOMEN'S HEALTH SPECIALISTS, LTD.**

**847-931-4747**

2350 Royal Blvd., Suite 600, Elgin, IL 60123

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**INSURANCE VERIFICATION**

Our office requires this form **72 hours prior to your visit**. Send us this completed form along with a copy of your CURRENT insurance card (Back & Front). Please fax this information or stop in to our office in Elgin. Thank you for your cooperation in managing your insurance stipulations. (You will also need to present your insurance card at your visits.)

**OUR INSURANCE OFFICE FAX: #847.622.3998**

**NAME OF INSURANCE COMPANY:** \_\_\_\_\_ **TYPE:** \_\_\_\_\_ **REFERRAL?** \_\_\_\_\_  
Primary Insurance Name HMO/PPO/POS/EPO/IPA Yes or No

**CO-PAY? \$** \_\_\_\_\_ **DEDUCTIBLE: \$** \_\_\_\_\_ **HOSPITAL SPECIFIED BY INS?** \_\_\_\_\_

**Mailing Address for Billing your Insurance Company:** \_\_\_\_\_  
 \_\_\_\_\_

**Phone # for Verification of Ins:** \_\_\_\_\_  
**Phone # for Approval of Services:** \_\_\_\_\_  
(If you have a secondary insurance company, please send us that information as well.)

**Patients Primary Care Provider:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**PCP's Fax #:** \_\_\_\_\_

**PATIENT INFORMATION**

**Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**DOB:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**Employer Name:** \_\_\_\_\_  
**Phones:** (H) \_\_\_\_\_  
 (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

**INSURANCE POLICY OWNER INFORMATION**

**Guarantor's Name:** \_\_\_\_\_  
**DOB:** \_\_\_\_\_ **SS#:** \_\_\_\_\_  
**Employed by:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_  
**Relation to Patient: Spouse, Parent, Self, Other**  
(Please circle)

*Do not repeat information if Patient & Policy owner are the same.*

**Appointment Date/Office:** \_\_\_\_\_ **Elgin** (Circle Office) **Algonquin**  
2350 Royal Blvd 2971 W Algonquin Rd

**Reason for your appointment:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*OFFICE USE ONLY:*  
Procedure/Service Approved: \_\_\_\_\_ Date of Approval: \_\_\_\_\_  
Completed by: \_\_\_\_\_

Name of Ins. Rep: \_\_\_\_\_ Representing: \_\_\_\_\_  
Policy Limitations: \_\_\_\_\_

Which HUB does this patient belong to? \_\_\_\_\_ Labs are sent to: \_\_\_\_\_

**APPROVAL #** \_\_\_\_\_