Employee/Policyholder Name:

Employer:

Patient name:

Relationship:

Date of service or appointment date:

A. Y N Is patient employed?
B. Y N Is there an employer sponsored health care plan offered by that employer to the patient?

C. Y N Has the patient been enrolled under any other health care plan within the past year? *

* If another plan enrollment is active or has terminated within the past year, we need the the plan information below.

Effective date of coverage: ___________________ Termination date (if applicable): _________________

Employer name (if applicable) ______________________________ Phone: _________________________

Health care plan: ____
Address: ____

Policy/Plan number: ______________________ Policyholder:_______________________________________

Level of coverage: ( )IND ( )EE/Spouse ( )EE/Child(ren) ( ) Family
Benefits: ( )Medical ( )Dental ( ) Vision

Employee Signature: ____ Date: _________________________

Phone Number: ____

FAX to: 302-629-8416

110 South Shipley Street Seaford DE 19973 800-959-3518 www.integratpa.com