Mukesh Patel, MD FCCP

Diplomate American Board of Pulmonary, Critical Care and Internal Medicine

PRE-REGISTRATION & INSURANCE VERIFICATION

DATE: ____/_____/_____ STAFF: _____

APPT MADE BY(PT/RF DR): _____ STAFF:_____ APPT GIVEN ___/___/_____@_____

PATIENT NAME: _____ DOB: ____/____/_____ SS#: _____/____/_____

ADDRESS: _____ CITY: _____ STATE:_____ ZIP:_____

EMAIL: _____

HOME PHONE: _____ ALT PHONE:_____ LIVING WILL: [] YES []NO

DX: _____ FU HOSP: _____ HOSPITAL: _____

LABS <6 MONTHS: _____ WHERE: _____ PT TO BRING _____ RF DR TO FAX _____

PFT <6 MONTHS: _____ WHERE: _____ PT TO BRING _____ RF DR TO FAX _____

CHEST <1 YEAR: XRAY/CT _____ WHERE: _____ PT TO BRING _____ NEED TO ORDER ____

REF DR: _____ PHONE: _____ PRIM DR: _____ PHONE: _____

*REQUEST LAST OFFICE NOTES, REPORTS RELATED TO CONDITION & AUTH TO BE FAXED TO OFFICE.
*REMIND PT TO BRING ACTUAL MEDICATION BOTTLES, PHOTO ID, INSURANCE CARDS & LIVING WILL.

PRIMARY INSURANCE

INS: _____ PH: _____ ID#_____GRP# _____

POLICY HOLDER: _____ RELATION: _____ DOB _____/_____/_____ SSN: _____/_____/_____

EFF: ___/___/____ DED$_____ MET$_____ COPAY$_____ COINS% _____ OOP$ _____ MET$ _____

PFT COV _____ AUTH REQ _____ COPAY$ _____ COINS % _____ AUTH#_____

CLAIMS ADDRESS: _____

REFERENCE# _____ VERIFIED _____/_____/_____ BY _____

SECONDARY INSURANCE

INS: _____ PH: _____ ID#_____GRP# _____

POLICY HOLDER: _____ RELATION: _____ DOB ____/____/_____ SSN: _____/_____/_____

EFF : ____/____/____ MG: _____ COVERS PRIMARY INS DED: _____ 2NDRY DED$_____ MET$_____

COPAY$_____ COINS% _____ OOP$ _____ MET$ _____ ROUTINE OV COV _____

PFT COV _____ AUTH REQ _____ COPAY$ _____ COINS % _____

CLAIMS ADDRESS: _____

REFERENCE# _____ VERIFIED _____/_____/_____ BY _____