ELITE WOMEN'S CARE, INC. **847-439-1894**
1555 North Barrington Road, Suite #410, Doctor's Office Building One, Hoffman Estates, IL 60169

Susan A. Orhan, M.D., F.A.C.O.G.

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 Hoffman Estates.

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: #847.439.1895

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 are the same.

ELITE
WOMEN'S CARE

Appointment Date/Office:_____ **Elk Grove** (Circle Office) **Hoffman Estates**
800 Biesterfield Rd **1555 N Barrington 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 # _____