Autism Systems LLC

Insurance Questionnaire

Please send completed form and a copy of the front and back of your insurance card to:

Fax: 18005623347 Email: autismsystems@gmail.com

Patient Name:_____ Patient DOB:_____ Age: _____

Patient S.S.#:_____ Gender: Male Female

Address:_____ City: _____ State:_____ Zip:_____

Referring Physician or Primary Care Dr.: _____
Diagnosis:_____ ICD-10 Diagnosis Code(s): _____

Parent(s) or Legal Guardian Name: _____
Guardian to contact for Insurance & Billing Related Questions: _____
Email Address: _____ Pn: _____

Insurance Company:_____ Cust Svc Pn: _____

Policy Holder Name: _____ Rel. to Patient: _____

Date of Birth:_____ SS#: _____ Phone: _____

Address (if different than above): _____

Policy #: _____ Group #: _____ Plan Type: _____

Individual or Group Policy:_____ *if Group*: Employer Name: _____

Secondary Insurance *leave blank if N/A*

Please provide Copy of Front & Back of insurance card:

Insurance Company:_____ Cust Svc Pn: _____

Policy Holder Name: _____ Rel. to Patient: _____

Date of Birth:_____ SS#: _____ Phone: _____

Address (if different than above): _____

Policy #: _____ Group #: _____ Plan Type: _____

Individual or Group Policy:_____ *if Group*: Employer Name: _____