STYMCO MEDICAL

Insurance Verification Form

(Send copy of insurance card if available)

Patient Name: _____ Date of Birth: _____

(please print clearly)

Next Appt. Date: _____ Date of Injury: _____ Length of Need: _____

Are you the Insured/Policyholder? ◯ Yes ◯ No *(If No, please complete the following)*

Policyholder Name: _____

Policyholder Address: _____

Policyholder Phone: _____ Policyholder Date of Birth: _____

INSURANCE INFORMATION *(please complete in full)*

◯ Major Medical ◯ Workers Compensation ◯ No-Fault ◯ Other _____

Primary Insurance Company: _____

Primary Insurance Phone Number: _____

Policy Number: _____

Group/Claim Number: _____

COVERAGE REQUESTED FOR MEDICALLY NECESSARY DEVICES *(please check ALL that will be prescribed)*

☐ TENS Device ☐ Microcurrent Device ☐ Interferential Device ☐ EMS Device

☐ Knee Brace ☐ Discovery 8/1000 (L0631) ☐ Braceback (L0627) ☐ Ankle Brace

☐ Wrist Brace ☐ Cervical Collar ☐ Conductive Garment ☐ Elbow Brace

ICD-9 / ICD-10 CODES: _____ _____ _____ _____

Primary Code *Secondary Code* *Tertiary Code* *Quaternary Code*

Physician Name: _____ Phone Number: _____

(please print clearly)

Please fax completed form to STYMCO: **(813) 922-3152** or email to **verify@stymco.com**