

1



2

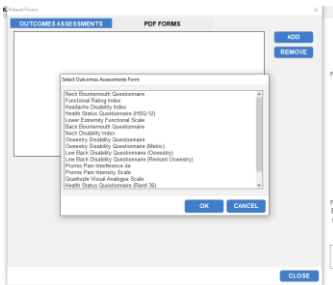
New Patient Data Collection Form
 (This portion of the call will reassure the patients that they have called the right place.)
 Name: Sally Jones
 Husband: Mark Jones
 "Who may we thank for referring you?"
 "What type of problem are you having?" Neck pain and stiffness
 "How long has this been going on?" 1 week "Result of accident?" Yes No
 "What have you done for this?"
 OTC Meds Tyenol Massage Saw DC
 Saw MD Other
 Appointment Date/Time: August 22 at 11 am
 Address: 123 Happy St DOB: 04/22/1955
 City: Niceville State: FL ZIP: 99999 Phone: 999-999-9999 Cell Home
 Email Address: sallyjones@hotmail.com

3

4



5



Do you have some kind of insurance that you'd like us to assist in filing for you? Yes No
 "Would you please get your insurance/Medicare Card/accident information so we can review it?"
 MAJOR MEDICAL INSURANCE UHC Insurance Company 800-965-4587 Phone Self Insured 04/22/1955 Insured DOB AP5864KL ID# 159753 Policy# Group# Employer
 MEDICARE Traditional Medicare MB#: K978G42FM01 Follow Through # Add'l Coverage? True Secondary, or Supplemental/Medigap OR Medicare Advantage Plan Name of plan: Office participates: YES NO
 ACCIDENT/INJURY Reported? YES NO Insurance Company Claim# Adjuster Phone# DOI Date: Time: Staff Member:
 WORKERS COMPENSATION Reported? YES NO Supervisor Phone# Supervisor or HR DOI Claim#
 Confirm Office Location NP Paperwork Website Email Discussed Fees/CHUSA YES NO
 "Offering a Good Faith Estimate is required per the No Surprises Act"

6

Major Medical Verification Form

Patient Account #: [Handwritten]

Section 1 - Patient Data
 Patient Name: [Handwritten]
 Address: [Handwritten]
 Insurance: [Handwritten]

Section 2 - Insurance Information
 Insurance Type: [Handwritten]
 Policy Number: [Handwritten]

Section 3 - Insurance Details
 Group Name: [Handwritten]
 Effective Date: [Handwritten]

Section 4 - Coverage Information
 Coverage Type: [Handwritten]

Section 5 - Additional Information
 [Handwritten notes]

Section 6 - Signature
 Signature: [Handwritten]

Section 7 - Date
 Date: [Handwritten]

Section 8 - Contact Information
 Phone: [Handwritten]

Section 9 - Other Information
 [Handwritten notes]

Section 10 - Final Remarks
 [Handwritten notes]

Section 11 - Footer
 [Handwritten notes]

Section 12 - KMC University Logo

7

Insurance Verification Software Interface

Patient Information
 Name: [Field]
 Address: [Field]
 Phone: [Field]

Insurance Information
 Policy Number: [Field]
 Group Name: [Field]
 Effective Date: [Field]

Verification Details
 Coverage Type: [Field]
 Status: [Field]

Buttons
 [Verify] [Cancel] [Print] [Close]

8



9