INSURANCE INFORMATION CHANGE FORM

Please complete this form when your health insurance coverage changes.

CLIENT INFORMATION

Legal name	Date of birth
Mailing address	Phone number

PREVIOUS INSURANCE

Previous insurance company / plan	Last day of coverage (end date)

NEW / CURRENT INSURANCE

New insurance company / plan	Coverage start date (effective date)
Member ID number	Group number (if applicable)

ADDITIONAL INSURANCE

Do you have another active insurance policy? [ ] No [ ] Yes

Other insurance company (if applicable)	Member ID (if applicable)

INSURANCE CARD & CLIENT ACKNOWLEDGMENT

Upload the front and back of your insurance card through our client portal, or stop by and see our receptionist so we can make a copy.

By signing below, I confirm that the information I provided is accurate. I understand that insurance benefits must be verified and that coverage verification does not guarantee payment for services.

Client / legal representative signature	Date

OFFICE USE ONLY

Date received: _____ Updated by: _____ Card on file: [ ] Yes [ ] No