

Insurance Information

*It is important to have **all of the information** so that you can be reimbursed by your insurance company in a timely manner.

Please be aware some of the information is not on your card and will require you to call and obtain this information by phone to complete this form. Thank you.

Policy Holder Name: _____ **DOB:** _____

Employer of Insured: _____

Insurance Company: _____

Insurance claims address : _____

Phone Number of Insurance Company: _____

Member ID#: _____

Group #: _____

Payor Id # _____

This form can be emailed back to: info@pdcofbuckhead.com