QCI Patient Information Medicare,
Commercial/Private Insurance, Other Benefit Plan
10/29/2016 PRB

QCI STAFF
Processed by (name)_____
Date received_____

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QCI provides services for English speaking patients at this time.
QCI will attempt to point non-English speaking individuals to appropriate resources to the best of our ability.

Patient Information Form (Medicare, Commercial/Private Insurance or Other Benefit Plan

Referral source: Self: ___Yes ___No Other:_____

Patient Name: (First, Last, Middle Initial) _____ Referral Date: _____

Patient Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Patient Phone #: _____ Patient Date of Birth: _____

Patient Gender: ___Female ___Male

Primary Insurance: _____ Authorization Needed: ___Yes ___No

Primary Insurance ID #: _____ Policy or Group #: _____

PAYOR ID #: _____ Phone # on back of card: _____

Patient Status:

___Single ___ Married ___Other ___Employed ___Full-time Student ___Part-Time Student

Primary Insurance Name of Insured: _____

Relationship to Patient: ___Self ___Spouse ___Child ___Other

Date of Birth of Insured: _____ Gender of Insured: ___Female ___Male

Employer's Name: _____ Insurance Plan Name: _____

Is there another insurance: ___Yes ___No

Name of other insurance: _____ Other Insurance Policy or Group #: _____

Other Insurance PAYOR ID #: _____ Phone # on back of card: _____

Name of Other Insured: (First, Last, Middle Initial) _____

Date of Birth of Other Insured: _____

Is there any other Benefit Plan? ___Yes ___No

Name & Phone # of Other Benefit Plan: _____

ID# of Other Benefit Plan: _____

Is Patient's Condition Related to:

Employment ___Yes ___No Auto Accident ___Yes ___No Other Accident: ___Yes ___No