# Over the Mountain Rehab, Inc.
# Insurance Informtion

**PRIMARY INSURANCE COMPANY NAME:** ___________________________________________

Policy ID Number: ________________________________ Group Number: _______________

Name of Insured: _______________________________________ DOB: __________________

Relation to Patient (please circle): Self Spouse Child Dependent-Other

**SECONDARY/OTHER INSURANCE COMPANY NAME:** __________________________________

Policy ID Number: ________________________________ Group Number: _______________

Name of Insured: _______________________________________ DOB: __________________

Relation to Patient (please circle): Self Spouse Child Dependent-Other

**IF THE PATIENT IS A MINOR:**

**(PERSON RESPONSIBLE FOR BILL PAYMENT)**

Name: ______________________________________ DOB: ___________________

Address: ____________________________________ City State ZIP: ______________________

Phone number: ____________________________ Relationship to Patient: ____________________

**IS THIS VISIT RELATED TO:**

☐ **Work Injury**

Payor: _________________________ Adjustor Name: ___________________________

Adjustor Phone: _____________________ Adjustor Fax: __________________________

☐ **Auto Accident**

Auto Insurance Company: _____________________ Policy #: ____________________

Accident Claim #: ________________________ Date of Accident: _________________

Representative Name: _________________________ Phone: ______________________

**FOR OFFICE USE ONLY:**

Deductible: ______________________ Remaining Deductible: _______________________

Co-Ins: __________________ Pre-Cert Required?: ___________ Auth. Visits: ____________

Authorization #: ___________________________ Auth. Dates: _______________________