No-Fault Verification
LAMBOY CHIROPRACTIC

Patient's Name:____

Address: ____
____

Social Security # ___________________

D.O.A.:__________________________

Claim # _________________________

Claims Adjustor: ___________________

Phone # ________________________

Insurance Company Name: ______________________________________

Address to send Bills to: _______________________________________
____
____

Person you spoke to at Insurance Company __________________________

Completed by __________________ Date __________________________

Spoke to Patient on ______________ Employee's Initials ________________

In the computer on ______________