

**Three Peaks Medical Management, LLC
Insurance Verification Information**

Please fill out all of the information below and either email or fax it to Hillary Olsen at hillary@texturedmotion.com or fax # 866-299-7386. We will verify your insurance within 1-2 business days, and Hillary will contact you.

Patient Name: _____

Primary Phone: _____
(# needs to be what the insurance co. has on file)

Address: _____

Date of Birth: _____ / _____ / _____
(month/day/year)

Social Security #: _____

Insured's Name: _____

Insured's SS #: _____
(only fill in the above two if you are under someone else's plan, i.e. spouse, parent, etc.)

Policy No/ Id #: _____

Group/Member #: _____

(Please identify every # which appears on ins. card. This will help expedite the process.)

Provider: _____
(insurance co)

Provider phone #: _____

Address for claims: _____

*Thank you for your time.
Please call Hillary if you have any questions about this form: 720.270.3633*