Cape Fear Health & Wellness, PLLC
eVisit
Please complete and email to
capefearhealth_wellnesss@ outlook.com

Insurance Verification Form

Date: ________________________________ Time: ___________________ am pm

Insurance: ____________________________ Telephone: ______________________________

Rep Name and Reference Number: ____

Patient First Name: _____________________________ Last Name: _______________________

Member ID: ___________________________________ DOB: ____________________________

Plan is:

____

Effective Date: ____

Additional Notes:

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