First Steps™
PEDIATRICS & ADOLESCENT MEDICINE

Insurance Coverage Verification

Patient Name: _____ Date of Birth: _____

Please contact your insurance company regarding your policy benefits before your visit to our office.

Insurance Company Name_____

Insurance Policy Number_____

First Steps Pediatrics is participating with my insurance company? YES NO

Does your insurance policy have Well Child/Preventative benefits? YES NO
If NO, please complete the Repeat/Sick section of this form.

Well Child/Preventative Coverage

Co-Pay_____ Deductible_____

Yearly Maximum_____ Policy Limitations_____

Immunizations	YES	NO
Routine Hearing	YES	NO
Routine Vision	YES	NO

Is the annual Well/Preventive visit renewed per:

Calendar year Enrollment year
(Please circle one)

Repeat & Sick Visits

Co-Pay_____ Deductible_____

Yearly Maximum_____ Policy Limitations_____

Parent/Guardian Signature_____ Date_____