International FPIES Association (I-FPIES)
319 Richmond Avenue
Point Pleasant Beach, NJ 08742

www.fpies.org
contact@fpies.org

# Insurance Information

Patient Name: _____

Person Completing This Form: _____

| | |
|---|---|
| Medicaid Number: | Medicaid/HMO Phone Number: |
| Name of Primary Person on Insurance: | Special Needs Coordinator Name/Phone #: |

**Primary Insurance**

Type of Insurance (General health, dental, vision, etc): _____

Insurance Company: _____

Policy and Group Number: _____

Guarantee Name and Company: _____

Phone # and Website: _____

Case Manager: _____

Is a prior authorization needed? _____

Email and Fax: _____

**Secondary Insurance**

Type of Insurance (General health, dental, vision, etc): _____

Insurance Company: _____

Policy and Group Number: _____

Guarantee Name and Company: _____

Phone # and Website: _____

Case Manager: _____

Is a prior authorization needed? _____

Email and Fax: _____

** Note: We also recommend keeping a copy of the insurance card in your care binder.