INTERNET
REQUEST FOR INSURANCE INFORMATION

This form allows Weight Loss Institute of Arizona to determine your benefits. This is a free service. The information you provide on this page is used solely for the purpose of verifying your insurance benefits. Please fill out and return to one of our representatives or fax to (480) 446-9475. Please call us at (480) 829-6100 if you have any questions.

Today's Date: _____

Name: _____
Address: _____
City: _____
State: _____ **Zip:** _____
Home Phone: _____ **Cell Phone:** _____
Work Phone and Extension_____**Email**_____
Primary Doctor: _____
Phone/Location:_____
Date of Birth: Month_____ Day_____ Year_____
Gender: ○Female ○Male **Height and Weight:** _____Feet _____ Inches _____LBS _____BMI
Does your insurance require a referral prior to your visit ? ○Yes ○No ○Unknown
Is Your Physician or PCP aware of this referral ? ○Yes ○No
Have you had a surgical weight loss procedure in the past ? ○Yes ○No Estimate Date_____
Procedure_____**Where Was Surgery Done**_____

Insurance Information: Primary Insurance:	Secondary Insurance:
Subscriber Number:	Subscriber Number:
Group Number:	Group Number:
Provider Phone Number:	Provider Phone Number:
Policy Holder Name/DOB:	Policy Holder Name/DOB:
Policy Holder Employer:	Policy Holder Employer:
Permission to use SS# if no ID# available Yes	No Social Security Number:

How did you learn about WLIA and its services?
○ Physician/PCP ○Family or Friend ○Internet/SEO ○ Billboard ○Radio ○Television
○Other: _____

CIRCLE THE MOST CONVENIENT WLIA OFFICE:

1-TEMPE 2-MESA/GILBERT 3-GLENDALE 4-WEST PHOENIX 5-TUCSON