

Health Insurance Verification Form



2830 South Central Avenue
Los Angeles, CA 90011
Phone 323/232-7653
Fax 323/232-0139 www.apch.org

Policy Number: _____

Medical Insurance Company: _____

Academic School Year: _____

Policy Holder Information

Policy Holder's name (first and last): _____

Permanent Address: _____

City: _____ State: _____ Zip code: _____

Current address (if different than permanent address): _____

City: _____ State: _____ Zip code: _____

Home phone number: _____

Mobile number: _____

Work number: _____

Employer's name: _____

Employer's address: _____

City: _____ State: _____ Zip code: _____

Student Information

Name (first and last): _____

Relationship to policy holder: _____