Elik Dialysis
Prospective Patients/Verification Form

Fill out and fax this form to 713-861-7502

Patients Name: _____Race: _____
HM Phone: _____ WK Phone: _____ Cell Phone: _____
Date of Birth_____ Address: _____
City_____ State_____ Zip: _____
Family Contact: _____ HM Phone: _____
Cell: _____

Nephrologists: _____Phone: _____

Type of Services: ☐Staff-assisted Hemodialysis ☐Peritoneal Dialysis

Primary Insurance Name: _____ Phone: _____
Effective Date: _____
Policy #: _____ Grp #_____
Policy Type: _____

Secondary Insurance Name: _____ Phone: _____
Effective Date: _____ Policy #: _____ Grp #_____
Policy Type: _____