INSURANCE INFORMATION

Name of ____ Primary Insurance Company _____

____ Secondary Insurance Company _____

Mailing Address for Insurance Company: _____

_____

Phone Number of Insurance Company: _____

_____

Insured's Name _____ Insured's ID # _____

Insured's Address _____ City _____ State ____ Zip _____

Phone #_____ Insured's Date of Birth _____ Insured's Group # _____

Employer's Name _____ Insurance Plan Name _____

Patient's Name _____ Patient's Relationship to Insured: Self □ Spouse □ Child □

Patient's Address _____ City _____ State ____ Zip _____

Phone # _____ Patient's Date of Birth _____ Patient Status: Single □ Married □ Other □

Employed □ Full-time Student □ Part-time Student □

Patient or Authorized Person's Signature
(I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)

Insured's or Authorized Person's Signature
(I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)

Signed _____ Date_____

Signed _____

Client to bill _____ Office to bill _____ DX Code _____