

Please fill out the information below as completely as possible to allow us to more effectively help you with our computerized insurance forms

PRIMARY INSURANCE

Name of Insurance Company: _____
Group/Plan #: _____ DIV.: _____
I.D./Certificate or Social Insurance#: _____
Employer's Name: _____

Name of Policy Holder: _____
Birthdate of Policy Holder: (DD/MM/YY) _____
Patient's Relation To Insured: _____

If you would like us to try to submit your claim electronically, please sign below:

"I authorize the release, to my insuring company plan administrator, the information contained in claims submitted electronically."

Signature of patient or parent/guardian

If you have SECONDARY INSURANCE COVERAGE, please fill out the information below:

Name of Insurance Company: _____
Group/Plan #: _____ DIV#: _____
I.D./Certificate or Social Insurance #: _____
Employer's Name: _____

Name of Policy Holder: _____
Relation To Patient: _____
Birthdate of Policy Holder: (DD/MM/YY) _____