INSURANCE INFORMATION

Medicare #:	Medicaid #:	
Insurance Co.:		Phone #:
Insurance Address:		
Group #:	Certificate or ID #:	
Insured's Name:	Relationship to Patient:	Self / Spouse / Dependent
Insured's Employer:		Phone #:
Employer's Address:		
Insured's Social Security #:	Date of Birth:	Sex: Male / Female

If the patient is covered by another insurance policy, please complete the following information for coordination of benefits. This information will enable your insurance company to process your claim more quickly. Thank you!

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Insurance Co.:		Phone #:
Insurance Address:		
Group #:	Certificate or ID #:	
Insured's Name:	Relationship to Patient:	Self / Spouse / Dependent
Insured's Employer:		Phone #:
Employer's Address:		
Insured's Social Security #:	Date of Birth:	Sex: Male / Female

I hereby assign, transfer, and set over to [Name of Practice] all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature Date