IF YOU ELECT TO HAVE YOUR VISITS SUBMITTED TO YOUR INSURANCE COMPANY, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Name of Primary Insurance Company:_____
(Please provide a copy of your insurance ID card)

ID #_____ Group #_____

Authorization # (if available)_____

Name of Insured:_____Date of Birth:_____

Other family members covered on this policy:

Name:_____DOB:_____Rel to Insured:_____

Name:_____DOB:_____Rel to Insured:_____

Name:_____DOB:_____Rel to Insured:_____

Does your policy require preauthorization for services? Yes_____ No_____

Did you contact your insurance company prior to today's visit? Yes_____ No _____

Do you have other insurance coverage? Yes_____ No _____
(If "yes", please provide a copy of your secondary insurance card.)

Although we do not routinely submit secondary claims, we do need to indicate that coverage on claims to your primary carrier. You will be responsible for submission of claims to secondary carriers.

If you are covered under Medicare, please note that your claims will be forwarded to your supplemental policy as well as to Medicare.