

For Provider Use ONLY:

**Provider Name:**

**Diagnosis Code:**

**Referring Provider:**

**Authorization #:**

**COMPLETE AND ACCURATE INFORMATION IS REQUIRED**

**PATIENT**

Patient Name \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Marital Status \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**RESPONSIBLE PARTY**

Name & address of person responsible for any balance not covered by insurance:

Same as Patient

Other

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**INSURANCE** Include copy of front & back of insurance card

Primary Insurance \_\_\_\_\_

Insurance Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber #: \_\_\_\_\_ Group#: \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

Insurance Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber #: \_\_\_\_\_ Group#: \_\_\_\_\_

**SUBSCRIBER**

Same as Patient

Same as Responsible Party

Other

Subscriber Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Patient Relationship to subscriber: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other (specify) \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

**INSURANCE AUTHORIZATION AND ASSIGNMENT: I hereby authorize the Provider of service to furnish information to insurance carriers concerning my condition and treatment. I hereby assign to the provider all payments for medical services rendered to my dependents or myself. I UNDERSTAND I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_