Insurance Information

Primary Insurance

Insurance Plan Name _____ ID Number _____

_____

Group Number _____

Insurance Address _____City _____State_____Zip____

_____

Insurance Phone _____-_____-_____ Copay $_____

Subscriber Name (Last, First, MI) _____

Subscriber DOB _____/_____/_____

Patient Relation to Subscriber (circle one) Self Spouse Child Other (specify)

_____

Insurance Information

I authorize treatment and agree to pay for all fees associated with such treatment. I authorize benefits to be paid directly to my provider. I authorize release of any information required to process my claim to Bel-Red Internal Medicine, PLLC and any other agent Bel-Red Internal Medicine, PLLC may contract with for billing services. I agree that I am financially responsible for all services provided and should it be necessary to refer the account to collections, I will be responsible for all collection fees, collection costs, attorney fees and court costs involved in my account.

Signature_____ Date

_____/_____/_____