Primary Insurance Coverage

Policy Holder's Name ___________________________________ Relationship to the Patient____________

SSN* _______________ Date of Birth _____________ Male/Female ___ Phone Number _______________

Address____

Ins. Co. ___________________________ Insured ID. No. _________________ Group No. ____________

Insurance Plan Name ___________________________________ Employer_________________________

Secondary Insurance Coverage

Policy Holder's Name ___________________________________ Relationship to Patient_______________

SSN* _______________ Date of Birth _____________ Male/Female ___ Phone Number _______________

Address____

Insurance Co. ___________________________________ Insured ID. No. ____________________________

Group No. ___________________ Employer _______________________

Insurance Plan Name ____

*Social Security numbers continue to be used for identification purposes by insurance companies and are invaluable for settling unpaid insurance claims. If you using an EAP, we must have your Social Security number to bill your insurance.

- **Please note:** Even if the primary insurance coverage will not pay for services, it must be filed for a response in order for secondary coverage to consider payment. Secondary coverage requires the dates of birth for policy holders. They may also require pre-authorization or notification.

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process insurance claims. I further authorize payment of medical benefits to the provider of services.

Signed ____ Date _____________________