Patient's Insurance Information and Signature Authorization

Name: _____ Date: _____
First Initial Last

SSN: _____ Date of Birth: _____Age: _____ Male / Female _____

Local Address: _____
Street City State Zip

Out-of-town Address: _____

Phone: _____ Work Phone: _____ Cell Phone: _____Email: _____

Occupation: _____ Employer: _____

Marital Status: □ Single □ Married □ Widowed □ Divorced

Spouses Name: _____

Primary Insurance Carrier: _____ (please present card for copying)

Insured's name: _____ Insured's Employer Name: _____

Insured's Relationship to patient: □ Self □ Spouse □ Parent □ Other: _____

Policy Number: _____ Group Number: _____ Effective Date: _____

Secondary Insurance Carrier: _____ (please present card for copying)

Insured's name: _____ Insured's Employer Name: _____

Insured's Relationship to patient: □ Self □ Spouse □ Parent □ Other: _____

Policy Number: _____ Group Number: _____ Effective Date: _____

Other Insurance Carrier: _____ (please present card for copying)

Insured's name: _____ Insured's Employer Name: _____

Insured's Relationship to patient: □ Self □ Spouse □ Parent □ Other: _____

Policy Number: _____ Group Number: _____ Effective Date: _____

LIFETIME MEDICARE B AND / OR INDEPENDENT INSURANCE SIGNATURE AUTHORIZATION

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize the holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare or Independent insurance claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services rendered to Jeffrey D. Phillips, O.D., P.A. OR authorize Jeffrey D. Phillips, O.D., P.A. to submit a claim to Medicare or Independent insurance company for payment to me.

I request that payment of any authorized MEDIGAP benefits be made on my behalf to Jeffrey D. Phillips, O.D., P.A. for any services rendered to me. I authorized any holder of medical information about me to release to my insurance company any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature: _____ Date: _____