

INSURANCE INFORMATION

Primary Insurance:

Insurance Company Name: _____

Billing Address: _____

Street City State Zip
 Phone Number:(_____) Certificate/ID#: _____ Group#: _____

IPA Group: _____ Plan: _____ Effective Date: ____ / ____ / ____

Copay Amount _____ Urgent Care Copay Amount _____

Subscriber Name if different than Patient: _____

Subscribers Date of Birth _____ Relationship to Patient: _____

Subscriber's address: _____
 Street City State Zip

Secondary Insurance:

Insurance Company Name: _____

Billing Address: _____

Street City State Zip
 Phone Number:(_____) Certificate/ID#: _____ Group#: _____

IPA Group: _____ Plan: _____ Effective Date: ____ / ____ / ____

Copay Amount _____ Urgent Care Copay Amount _____

Subscriber Name if different than Patient: _____

Subscribers Date of Birth _____ Relationship to Patient: _____

Subscriber's address: _____
 Street City State Zip

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS:

I hereby authorize and request the insurance company(s), or agent thereof, to pay directly to Mission Heritage Medical Group for services provided to me by Mission Heritage Medical Group.

I am aware that I am financially responsible for charges not covered by this assignment. I authorize refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

This signature will also serve as an authorization to release medical information necessary to satisfy payment.

 Signature of Patient (If minor, signature of responsible party)

 Date

 Print Patient Name

 Patient Date of Birth