## INSURANCE INFORMATION

Do you have insurance? YES ☐ NO ☐

If yes, which do you have Medicare PPO through employer Private

***Primary Insurance Name***:_____

Address:_____

ID#:_____ Group#:_____ Plan name or #:_____

Name of Insured:_____ Birth Date:_____ Social Security #:_____

Please provide a copy of insurance card

What is your yearly deductible? $_____ Have met your deductible?_____

Do you have Medicare Supplemental Insurance? YES NO

***Secondary Insurance Name***:_____

Address:_____

ID#:_____ Group#:_____ Plan name or #:_____

Name of Insured:_____ Birth Date:_____ Social Security #:_____

What is your yearly deductible for your supplemental? $_____ Have you met your deductible?_____

If yes, please attach for photocopying

PLEASE READ THE LIFETIME AUTHORIZATION AND SIGN FOR OUR FILE.

I authorize any holder of medical or other information about me to release to the Socail Security Administration and health Care Financing Administration or its intermediaries or carriers, to my insurance company, or to the billing agent or the physician or supplier, any information needed for this or a related Medicare claim, or any other insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I authorize my insurance company to pay medical benefits to undersigned physician for services rendered. I understand and agree that I will be personally responsible for any charges not paid by my insurance company. I authorize the release of any medical information necessary to process this claim for payment of insurance.

_____ _____

Signature Date