

INSURANCE INFORMATION

Primary Medical Coverage (Insurance, Medicare, Medicaid/Welfare)

Company name _____ Policyholder/Insured party _____
Address _____ Policyholder birth date (if not pt.) _____
_____ Group # _____
_____ ID # _____
Phone number (_____) _____ Payer ID# _____
Social Security # of the insured if the patient is not the policyholder. _____ - _____ - _____

Secondary/Supplement Medical Coverage (if applicable)

Company name _____ Policyholder/Insured party _____
Address _____ Policyholder birth date (if not pt.) _____
_____ Group # _____
_____ ID # _____
Phone number (_____) _____ Payer ID# _____
Social Security # of the insured if the patient is not the policyholder. _____ - _____ - _____

Third Insurance (if applicable)

Company name _____ Policyholder/Insured party _____
Address _____ Policyholder birth date (if not pt.) _____
_____ Group # _____
_____ ID # _____
Phone number (_____) _____ Payer ID# _____
Social Security # of the insured if the patient is not the policyholder. _____ - _____ - _____

Do any of your insurance companies require preauthorization certification? Yes / No

Phone number (_____) _____

Acknowledgment and Release

The Clinic holds the patient fully responsible for payment for all services. The Clinic will file claims to your insurance company if you provide us with the complete and accurate information necessary. I hereby authorize Willcockson Eye Associates, P.C. to release any information acquired in the course of my examination or treatment to my insurance company or third party payors I may designate. Further I authorize payment directly to the Clinic. I understand I am financially responsible to the Clinic for charges not covered by this authorization.

X _____ Date _____
Patient or parent/guardian signature

All Medicare patients must read and sign:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Willcockson Eye Associates, P.C. for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare-assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

X _____ Date _____
Patient or parent/guardian signature