INSURANCE DATA FOR ELECTRONIC FILING
(Used only for Commercial Insurance, not Medicaid or Chip)

PATIENT INFORMATION

NAME: ____ GENDER:

DATE OF BIRTH: ________________________________

ADDRESS: ____

CITY: _________________________ STATE: ________ ZIP: _________

INSURED INFORMATION

POLICY HOLDER NAME: ____

POLICY HOLDER DATE OF BIRTH: ___________________

RELATION TO PATIENT: (i.e. self, parent)____

ADDRESS (if different than above): ____

CITY: _________________________ STATE: __________ ZIP: _________

PHONE NUMBER: __________________________________

EMPLOYER: _______________________________________

NAME OF INSURANCE: ______________________________

POLICY NUMBER: _________________________________

GROUP NUMBER: __________________________________

AUTHORIZED SIGNATURE(S)

PATIENT OR GUARDIAN: *I authorize the release of any medical information or other information necessary to process insurance claims for the above patient. I also request payment of medical benefits either to myself or to the party who accepts assignment.*

Signed: ______________________________________ Date: ________________

Printed Name: ___________________________________