Insurance Information Form

(Do **Not** fill out if you only have Medicaid or No insurance)

Primary Insurance Information

Patient name _____ Date of Birth_____

Primary Insurance Co_____

Policy Holder_____

Date of Birth_____ Soc Sec #_____

Employer _____

Group # _____ Member ID # _____

Insurance Telephone # (___)_____

Secondary Insurance

Secondary Insurance Co_____

Policy Holder_____

Date of Birth_____ Soc Sec #_____

Employer _____

Group # _____ Member ID # _____

Insurance Telephone # (___)_____

Please Provide Insurance Card to Receptionist

I hereby authorize the listed insurance company(s) to pay directly to The Pediatric Center of Southwest Louisiana benefits due me, if any, as provided in the unexpired policy. I will pay all charges in excess of whatever sum may be paid. I authorize The Pediatric Center of Southwest Louisiana to release information to the insurance company for my claims to be paid.

_____ _____ _____

Name Signature Date

(For Office Use Only)

Guarantor Name_____

Account #_____

Chart Entered By_____