Patient Insurance Information

Patient Name _____

PRIMARY Insurance Carrier: _____

Subscriber's Name: _____ Relation:_____

I.D. Number: _____ Insurance Phone: _____

Group Number or Name: _____

Insurance billing address: _____
Street address or P.O. Box

_____
City State Zip Code

SECONDARY Insurance Carrier: _____

Subscriber's Name: _____ Relation:_____

I.D. Number: _____ Insurance Phone: _____

Group Number or Name: _____

Insurance billing address: _____
Street address or P.O. Box

_____
City State Zip Code

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***As a service to our patients, we are happy to process your health insurance claims for you. However, it is important for you to understand that it is your responsibility to know your own insurance benefits and eligibility. If you have any questions or need any information regarding our participation status with you insurance companies, contact your carrier or feel free to ask us.

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to: Michael M. Papalian, M.D. I understand that I am responsible for obtaining any insurance authorization for services rendered here and that I am financially responsible for non-covered or non-authorized services. I further authorize Michael M. Papalian, M.D. to release to my insurance carriers any information required to process my claims.

SIGNED:_____DATE:_____
(Patient or Guardian, if minor)