CBMC

Authorization to Bill Insurance

SECTION 1: Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

DOB: _____ SS#: _____ Daytime Phone: (_____)_____

Address_____ City_____ State_____ Zip_____

Preferred Language: _____ Email Address: _____

Race (Please circle one): American Indian or Alaska Native
Asian
African American
Native American or Pacific Islander
White
Prefer not to specify

Ethnicity (Please Circle One): Hispanic or Latino
Not Hispanic or Latino
Prefer not to specify

SECTION 2: Benefits and Billing Information

Who is your Primary Care Provider?: Dr. _____ Clinic Phone #: (_____)_____

Clinic Address: _____ City:_____ State: _____ Zip Code: _____

Does your plan require you to have a referral from you Primary Care Provider to receive coverage? Yes* No

*If yes, which licensed provider were you referred to at our clinic?:_____

I. Primary Insurance Company & Plan Name: _____

ID Number: _____ Group/Policy Number: _____

Name of policy holder:_____ Policy holder's DOB: _____ Policy holder's SSN#_____

Address of the policy holder_____ City_____ State_____ Zip_____

The policy holder is my: _____ (specify relationship) Policy holder's gender (circle): Male Female

Is your Primary Insurance Policy a (circle): POS PPO EPO HMO Don't Know Other (specify): _____

II. Secondary Insurance Company & Plan Name: _____

ID Number: _____ Group/Policy Number:_____

Name of policy holder:_____ Policy holder's DOB: _____ Policy holder's SSN#_____

Address of the policy holder_____ City_____ State_____ Zip_____

The policy holder is my: _____ (specify relationship) Policy holder's gender (circle): Male Female

Is your Secondary Insurance Policy a (circle): POS PPO EPO HMO Don't Know Other (specify): _____

III. Tertiary Insurance Company & Plan Name: _____

ID Number: _____ Group/Policy Number:_____

Name of policy holder:_____ Policy holder's DOB: _____ Policy holder's SSN#_____

Address of the policy holder_____ City_____ State_____ Zip_____

The policy holder is my: _____ (specify relationship) Policy holder's gender (circle): Male Female

Is your Tertiary Insurance Policy a (circle): POS PPO EPO HMO Don't Know Other (specify):_____

SECTION 3: Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name: _____ First Name:_____ Middle Initial: _____

Relationship to patient: _____ SS#:_____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number : (_____)_____ Alt Phone Number: (_____)_____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X _____ _____

Guarantor's Signature **Date**

SECTION 4: Next of Kin

Last Name: _____ First Name:_____ Middle Initial: _____

Relationship to patient: _____ Phone Number : (_____)_____

Address: _____ City: _____ State: _____ Zip: _____

I understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that some third-party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize Cancer/Blood & Medicine Clinic LLC to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, sexually transmitted diseases, HIV/AIDS and mental health. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

X _____ _____

Patient's Signature Date

X _____ _____

Guardian/Representative's Signature Date

_____

Relationship to Patient/Representative Authority