



# Insurance Authorization



Guarantor # \_\_\_\_\_

Signing this document will allow Children's Medicine, P.C. to file your insurance. It will also allow your insurance Company to send check(s) directly to Children's Medicine, P.C.

- I authorize the release of any information necessary to process any/ all claims
- I authorize payment of medical benefits to go to Children's Medicine, P.C.
- I understand that if my insurance company does not cover a service, I will be responsible for payment.
- I have read and understand the "Fees and Payment Policies"

\_\_\_\_\_  
Patient/Parent/ Guardian Printed Name

\_\_\_\_\_  
Patient/Parent/Guardian Signature

\_\_\_\_\_  
Date

Please list all patients covered on this policy:

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Full Name of Insured/Subscriber \_\_\_\_\_

Insured/Subscriber Social Security Number \_\_\_\_\_

Full Name of Insurance Company \_\_\_\_\_

ID/Policy/Member Number \_\_\_\_\_

Group Number \_\_\_\_\_

Date of Birth of Father \_\_\_\_\_ Date of Birth of Mother \_\_\_\_\_