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_____