Primary Insurance Information

Insurance Name:	
Insurance ID/Member #:	**Group #:**
Name of Insured:	**Relationship to insured:**
Insured's SS#:	**Insured's Date of Birth:**
Insured's Employer:	
Claims Address:	
Insured's Phone #:	**Insurance Phone #:**

Do you have a secondary insurance policy? ____ Yes _____ No

I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization to be used in place of the original. I hereby authorize my healthcare provider to apply for benefits on my behalf for covered services rendered by her. I request that payment from my insurance company be made directly to my healthcare provider. The insurance information provided above represents my complete coverage. I am not covered by any other insurance at this time. I understand that I am responsible for any financial obligations not covered by my insurance. I certify that the information, which I have provided above, is correct.

Signature_____ Date:_____

For Office Use Only

DX Code:	Procedure Code:	Auth #:
Copay:	Contracted Rate:	Date to Date:
MH Net BCBS Aetna Ceridian PHCS ARC/Aria Medicare Medicaid United Other:		