Insurance Demographics Update

Insurance Name:

Policy Holder Name:

Policy Holder Insurance ID#:

Patient Name:

Patient ID# (if different):

Type of coverage:

____Medical ____Dental ____Vision ____Life ____Pharmacy ____Disability

Do you or any other family member have other insurance coverage? ___Yes ___No

(This includes COBRA, Foreign Health Coverage, etc. Please make a copy of this page and complete if you need additional space.)

Name of other insurance ____

Group Number ____________________ Policy # ____________________

Effective date ____________________ Term date ______________________________

Type of coverage:

____Medical ____Dental ____Vision ____Life ____Pharmacy ____Disability

Policy Holder ______________________ Date of Birth ___________________________

Name of other insurance ____

Group Number ____________________ Policy # ____________________

Effective date ________________________ Term date __________________________

Type of coverage:

____Medical ____Dental ____Vision ____Life ____Pharmacy ____Disability

Policy Holder ________________________ Date of Birth ________________________

Medicare information

Do you or any other family member have Medicare? ____Yes ____No

If yes, please submit a copy of your Medicare Card.

Do you have Medicare Part D, prescription coverage? ____Yes ____No

If separated or divorced

Please complete the following for dependent children in order to determine which coverage has primary liability.

Which parent has physical custody of the child?

Name ________________________________ Date of Birth _____________________

Is there a court order making one parent responsible for the child's medical/dental/vision expenses? ____Yes   ____No

Has the parent with custody remarried? ____Yes ____No

If Yes, does the step-parent cover this child? ____Yes ____No

If Yes, please provide:

Insurance Name:

Policy Holder Name:

Participant ID #:

Patient Name:

Name of other insurance ____

Group Number ___________________ Policy # ___________________

Effective date ________________________ Term date ___________________________

Type of coverage:

____Medical ____Dental ____Vision ____Life ____Pharmacy ____Disability

Please provide a telephone number where we may reach you if additional information is needed:

(____)____________________

I certify that the above information is true to the best of my knowledge. I authorize any physician, facility, insurance company, or employer to release information to the Plan Supervisor/Claims Processor.

____ ____________________________

Signature Date

____ ____________________________

Signature of Dependent (if 18 years of age) Date

____

Printed Name of Person Signing Form