CENTENARY FAMILY & URGENT CARE

INSURANCE INFORMATION AND VERIFICATION

THE PATIENT SHOULD COMPLETE ALL ITEMS IN YELLOW IN THE WAITING ROOM

Witness Signature:_____

Date: _____

PATIENT INFORMATION

NAME:_____
TODAY'S DATE:_____
BIRTH DATE:_____
SS#:_____
DRIVERS LICENSE #:_____
RELATIONSHIP TO INSURED:_____
REASON FOR TODAY'S VISIT:_____
_____
(OBTAIN EMPLOYER/ADDRESS INFORMATION FROM FILE)

INSURED INFORMATION

NAME:_____
BIRTH DATE :_____ **SS#**_____
DRIVERS LICENSE #_____
EMPLOYER:_____
_____
EMPLOYER PHONE #:_____

INSURANCE INFORMATION

NAME OF INSURANCE: _____
PHONE #:_____
IS THIS AN EMPLOYER SPONSORED INSRANCE PLAN? _____ YES _____ NO
PLEASE PRESENT INSURANCE ARD TO STAFF FOR A COPY
POLICY #_____
GROUP #_____
INSURED ID #_____
PATIENT ID #_____

Patient Statement: I (insured/patient) , authorize the release of any medical information necessary to process this claim, I also authorize payment of medical benefits to the undersigned physicians or supplier for any medical services.

Patient/Insured Signature: _____
Date: _____

********OFFICE USE ONLY BELOW THIS LINE*******

INSURANCE VERIFICATION

PHONE # CALLED:_____
DATE &TIME CALLED:_____
SPOKE WITH:_____
EFFECTIVE DATE:_____
DEDUCTIBLE:$_____**/ $**_____ **OF DEDUCTIBLE HAS BEEN MET**
WILL DED. CARRY OVER INTO NEW YEAR? _____
CENTENARY FAMILY URGENT IN NETWORK? __ YES _ NO
INSURANCE PAYS AT:
100% 90% 80% 70% 60% 50% 40% 30% 20%
PATIENTS PAYS:____% PER VISIT OR
SET C0-PAY OF $_____ PER VISIT
OUT OF POCKET$_____ LIFETIME MAX $_____

RESON/TODAYS VISIT OR SPECIAL SERVICES	PAYS AT $OR%	NOTES	VERIFIED DATE	STAFF
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

MAIL CLAIMS TO:_____
MEDICARE:_____ **MEDICAID:**_____
TEXAS STAR PROGRAM? _____ YES _____ NO
PRIMARY CARE PHYSICIAN:_____ **IF NOT DR.MILLER/ INITA GRIFFIN, NP, EITHER HAVE PATIENT CHANGE PCP OR GET REFERRAL PRIOR TO TREATMENT.**

STAFF MEMBER COMPLETING FORM:_____