Buffalo Trace Medical Arts

611 Forest Avenue, Maysville, KY 41056
Phone: 606-564-4016 Fax: 606-564-8288
Email: info@comprehendinc.org

Billing / Insurance Information

Primary Insurance

Client's Name: _____

Client's Relationship to Insured:
(Self, Spouse, Child, Other) _____

Insured's Name:
(if different from Client) _____

Insured's Address: _____
_____

Insured's Date of Birth:

Insurance Company Name / Plan: _____

Insured's Employer: _____

Group #: _____ **Policy #:** _____

Medicaid #: _____ **Medicare#:** _____

Is there other insurance coverage for which you qualify? ☐ Yes ☐ No

Secondary Insurance

Client's Name: _____

Client's Relationship to Insured:
(Self, Spouse, Child, Other) _____

Insured's Name:
(if different from Client) _____

Insured's Address: _____

Insured's Date of Birth: _____

Insurance Company Name / Plan: _____

Insured's Employer: _____

Group #: _____ **Policy #:** _____

Medicaid #: _____ **Medicare#:** _____

Is there other insurance coverage for which you qualify? ☐ Yes ☐ No

******Authorization is repeated on "Receipt of Forms & Information"******

I authorize Buffalo Trace Medical Arts to release to my third party payor any medical or psychiatric information (including any documents or reports requested) that may be required to process my claim with my primary or secondary payor listed above.

I understand that my claims cannot be processed without this release. I further understand that I may be billed at a future date for any services not covered by my policy. I agree to pay for any services not covered by my policy, based on Buffalo Trace Medical Arts's sliding fee scale.

I hereby authorize and instruct my insurance company to make any benefits payable to Buffalo Trace Medical Arts.

Signature of Patient / Representative	Relationship to Patient	Date	Staff Signature	Date