1325 Airmotive Way
Suite 240
Reno, Nevada 89502
(775) 737-9001 phone
(775) 870-1628 fax

Coordination of Benefits for Insurance Coverage

Primary Insurance Company Name: ____

If you have other insurance in addition to your primary coverage, we will need your other insurance information to send to your primary insurance company. By coordinating benefits amount all insurance carriers, you will receive the maximum benefits available. (***Require Fields**)

*** Name of Patient: _________________________________ *Date of Birth: ___________________**

***Name of Insured: _________________________________ *Phone#: _______________________**

***Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _________________________**

***Group or Claim#: ___________________________ *Subscriber/Member#: ___________________**

***Does the Patient have other insurance or Medicare/Medicaid coverage?**

☐ Yes → Continue with Form ☐ No → Go to Signature section

<u>OTHER INSURANCE CARRIER:</u>

*** Name of the Subscriber for the Other Insurance Policy: __________________________________**

***Name of the Employer: ____**

***Name of Other Insurance Carrier: ____**

***Insurance Carrier Claim Address: ____**

***Insurance Carrier Phone#: ____**

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*Policy#: ________________________________ *Group#: _____________________________

*Beginning Date of Coverage: ______________ *End Date of Coverage (if applicable): _______

Other Insurance Covers? ☐ Self ☐ Spouse ☐ Child ☐ Other: __________________________

SIGNATURE: ____

*Insured or Patient Name (print): ____

*Signature of Insured or Patient: _________________________________ Date: ______________