

DATE:

PATIENT NAME

DATE OF BIRTH

PATIENT SOCIAL SECURITY #

**BILLING INFORMATION**

PLEASE BILL TO:  PATIENT  MEDICAID  MEDICARE  INSURANCE - IS YOUR INS. PPO HMO

**PRIMARY INSURANCE**

NAME OF INSURANCE COMPANY:

INSURANCE COMPANY ADDRESS CITY STATE ZIP CODE

NAME OF POLICY HOLDER IF OTHER THEN PATIENT: D-O-B OF POLICY HOLDER INSURED'S EMPLOYER

SSN IF OTHER THEN PATIENT SUBSCRIBER'S ID# POLICY # GROUP #

**SECONDARY INSURANCE**

NAME OF INSURANCE COMPANY:

INSURANCE COMPANY ADDRESS CITY STATE ZIP CODE

NAME OF POLICY HOLDER IF OTHER THEN PATIENT: INSURED'S EMPLOYER

SSN IF OTHER THEN PATIENT SUBSCRIBER'S ID# POLICY # GROUP #

DOES YOUR PLAN REQUIRE A REFERRAL YES NO

**MEDIPLAN INFORMATION**

TO BETTER SURVE YOU WE REQUIRE FOR YOU TO PRESENT YOUR MEDICAL CARD FOR EVERY VISIT

PERSON ELIGIBLE ID#

CASE ID NUMBER ELIGIBILITY PERIOD

**ASSIGNMENT AND RELEASE**

I hereby authorized Chicago Maternal-Fetal Medicine to release information received, including without limitation, medical information to my health plan/Insurance carrier and its authorized representatives

I hereby assign payment to Chicago Maternal-Fetal Medicine for surgical and or medical benefits otherwise payable to me. I understand that I am financially responsible for charges incurred.

I acknowledge by signing that I have received the business policies and **Notice of Privacy Practices and Notice of individual rights**

**I understand that I will incur a \$45.00 fee for any appointment cancellation less then 24 hours.**

Signature \_\_\_\_\_ Date: \_\_\_\_\_