Coordination of Benefits

* indicates REQUIRED fields, as applicable

*** Please PRINT All Fields LEGIBLY**

FULL NAME OF PATIENT:_____ **DATE OF BIRTH**:_____

INSURANCE COMPANY:_____ *Type of Plan: □PPO □HMO □ Other _____

*Policy Holder Full Name:_____ *Policy Holder DOB:_____

*Policy Holder Home Address:_____ Policy Holder Phone #:_____

Policy Holder Employer:_____*Relationship to Patient: □ Self □ Spouse □ Parent □ Other _____

*Subscriber / Member ID#: _____ *Group or Claim #:_____

Insurance Providers Phone#: _____ Insurance Carrier Claim Address: _____

Financially Responsible Party

******If SELF**, please put self and you will have completed the Financially Responsible Party portion of this form
**********Please note**: the financially responsible party **DOES NOT HAVE TO BE THE MAIN POLICY HOLDER**, but **MUST** be a legal adult and provide **ALL** of the required information below along with their **SIGNED CONSENT** at the bottom of this form.

***Full Name Of The Responsible Party For The Patient**:_____

***Date of Birth**: _____/_____/_____ ***Relationship to Patient**: □ Spouse □ Parent □ Other _____

***Mailing Address**: _____ **Apt #**: _____

***City**: _____ ***State**: _____ ***Zip**: _____ ***Phone** #:(_____)_____-_____

*Does the PATIENT have ANY additional insurance coverage?

□ YES » Continue with form □ NO » Go to **Signature** section

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OTHER INSURANCE COMPANY:

* Name of **Secondary** Insurance Carrier: _____
* Name of the Policy Holder:_____ *Policy Holder DOB:_____
* Relationship to Patient: □ Self □ Spouse □ Parent □ Other _____
* Policy Holder Home Address (if different from patients):_____
* Policy Number: _____ *Group Number: _____
* Insurance Carrier Providers Phone Number: _____
  Insurance Carrier Claim Address: _____

OTHER INSURANCE COMPANY:

* Name of **Tertiary** Insurance Carrier: _____
* Name of the Policy Holder:_____ *Policy Holder DOB:_____
* Relationship to Patient: □ Self □ Spouse □ Parent □ Other _____
* Policy Holder Home Address (if different from patients):_____
* Policy Number: _____ *Group Number: _____
* Insurance Carrier Providers Phone Number: _____
  Insurance Carrier Claim Address: _____

I certify that the above information is correct and understand that I am obligated to provide this information to the appropriate insurance company. Failure to provide complete and accurate information may result in a delay in the payment of benefits or denial of claims. Texas Residents: any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

SIGNATURE:

***Print Full Name of Financially Responsible Party**: _____

***Signature of Financially Responsible Party**: _____ ***Date**: _____