Insurance Information

SUBMIT FORM

Patient's First Name: _____ Patient's Last Name:_____ Today's Date _____

(Primary Insurance)

Name of Insurance Company: _____

Claims Address: _____

City:_____ State: _____ Zip: _____

Insured's Name: _____ Policy ID Number: _____

Group Number: _____ Adj. Name: _____

Claim Number *(if applicable)*: _____ Adj. Phone: _____

(Secondary Insurance)

Name of Insurance Company: _____

Claims Address: _____

City:_____ State: _____ Zip: _____

Insured's Name: _____ Policy ID Number: _____

Group Number: _____ Adj. Name: _____

Claim Number *(if applicable)*: _____ Adj. Phone: _____

How did the injury occur?

_____

_____

_____

Was the injury work related? Yes ◯ No ◯

Was injury related to motor vehicle accident? Yes ◯ No ◯

Date of injury/accident: _____

Was injury/accident reported? Yes ◯ No ◯

This office will file insurance claim with your primary insurance. Your second insurance will be filed only when there is a "crossover" between insurance companies, or in the case of referral submission required by insurance. If you know there is no "crossover" to your secondary and your secondary is not a referral plan you will be responsible for submitting to receive reimbursement.

I authorize the release of any medical information necessary to process my claim.

Signed: _____
(Patient or Responsible Party)

Date:_____

I authorize payment of medical and surgical benefits to "Advanced Orthopaedic Associates."

Signed: _____
(Patient or Responsible Party)

Date:_____