SOUTHERN VASCULAR CLINIC

INSERT PATIENT LABEL HERE

Insurance Information

PRIMARY INSURANCE CARRIER

Name:_____ Phone Number: _____

Policy Number:_____ Group Number:_____

Insured's Name:_____ Relationship to Patient:_____

Insured's Social Security Number: _____-_____-_____ Date of Birth: _____

SECONDARY INSURANCR CARRIER

Name:_____ Phone Number: _____

Policy Number:_____ Group Number:_____

Insured's Name:_____ Relationship to Patient:_____

Insured's Social Security Number: _____-_____-_____ Date of Birth: _____

FOR MEDICARE PATIENTS ONLY

Payment Policy:

Medicare: We are a participating provider of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% co-payment. We do file with secondary/supplemental insurance carriers, however, in the event that the secondary does not pay within 60 days, the patient will be balance billed.

I authorize any holder of medical or other information about me to release the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature (as it appears on Medicare card): _____ Date:_____

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file. I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature:_____ Date:_____