Insurance Information

Primary Insurance

Insurance Plan Name_____ ID Number_____

Group Number_____

Insurance Address_____ City_____ State_____ Zip_____

Insurance Plan Phone _____-_____-_____ Co-Pay $_____._____

Subscriber Name (Last, First, MI)_____

Subscriber DOB_____/_____/_____

Patient Relation to Subscriber (circle one) Self Spouse Child Other (please list)_____

Secondary Insurance

Insurance Plan Name_____ ID Number_____ Group Number_____

Insurance Address_____ City_____ State_____ Zip_____

Insurance Plan Phone_____-_____-_____ Co-Pay $_____._____

Subscriber Name (Last, First, MI)_____

Subscriber DOB_____/_____/_____

Patient Relation to Subscriber (circle one) Self Spouse Child Other (please list)_____

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Insurance Information

I authorize treatment and agree to pay for all fees associated with such treatment. I authorize benefits to be paid directly to my provider. I authorize release of any information required to process my claim to Bel-Red Internal Medicine, PLLC and any other agent Bel-Red Internal Medicine, PLLC may contract with for billing services. I agree that I am financially responsible for all services provided and should it be necessary to refer the account to collections, I will be responsible for all collection fees, collection costs, attorney fees and court costs involved in my account.

Signature_____ Date _____/_____/_____