

Doctor: _____

Location: _____

Chart# _____

Patient Name: _____ Date: _____

Birth date: _____ Sex: M F

Patient's Social Security Number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

County: _____ Phone Numbers: Home: _____

Work: _____ Cell: _____ Email address: _____

Guardian's Name: _____

Employer/Retired/Unemployed: _____

Employer's Address: _____

Guardian's Social Security# : _____ Birth date: _____

Cell Number: _____ Emergency Contact other than Guardian: _____

Relationship: _____

Phone # Home: _____ Work: _____ Cell: _____

Is the patient a resident of a skilled nursing facility or receiving care under hospice benefits? Yes No

Facility Name and Address: _____

Facility Phone#:

Do you have a primary care physician? Y N NA If yes, name and address / phone: _____

PEDIATRIC/PEDIATRIC SPECIALTY

PRECERTIFICATION AND REFERRALS

If your insurance company requires preadmission certification or office referrals, it is your responsibility to see that we notify your insurance company prior to all admissions or office visits. Any charges not covered as a result of non-certification will be your responsibility.

Guardian Signature: _____

OFFICE FINANCIAL POLICY

INSURANCE AUTHORIZATION: I request that payment under the medical insurance program be made to the provider for any bills for services rendered to me during the effective period of this authorization. I authorize this provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or related Medicare claim. I further permit a copy of this authorization to be used in place of the original. This authorization is to apply to all private insurance claims submitted by the provider on my behalf.

Guardian Signature: _____

I am responsible for all financial obligations of health services for the above patient, and for reimbursement and payment of claims from my insurance company. I am responsible for providing the name of the preferred hospital, laboratory or any other preferred facility / physician in network with the insurance plan to Memorial Health University Physicians. If for any reason the account should become delinquent, I agree to pay for all rebilling charges, collection costs, and reasonable legal fees.

Guardian Signature: _____

Please remember, it is the guardian's responsibility to complete and update this information as needed. Any charges incurred due to incorrect information will be the guardian's responsibility.

Name of Primary Insurance Plan: _____

Please check appropriate boxes: Group Private Cancer Medicare Medicare Supplement
Medicare Advantage Medicaid Medicaid HMO Worker's Compensation Tricare

Policy Number: _____ Group Number: _____

Name of Subscriber: _____ Subscriber Birth date: _____

Relationship to Patient: _____ Subscriber Sex: M F

Does your primary insurance require referral numbers? Yes No Phone Number: _____

Does your primary insurance require pre-certification? Yes No Phone Number: _____

If your insurance does not allow use of Memorial's Lab what is the preferred lab? _____

Name of Secondary Insurance Plan: _____

Please check appropriate box: Group Private Cancer Medicare Supplement Medicare Advantage
Medicaid Medicaid HMO Worker's Compensation Tricare

Policy Number: _____ Group Number: _____

Name of Subscriber: _____ Subscriber Birth date: _____

Relationship to Patient: _____ Subscriber Sex: M F

Address to mail claim: _____

Does your secondary insurance require referral numbers? Yes No Phone Number: _____

Does your secondary insurance require pre-certification? Yes No Phone Number: _____

Who is your secondary insurances preferred lab? _____

Do you have prescription coverage? Yes No Program Name: _____

GUARDIAN TO COMPLETE IF APPLICABLE:

IF YOU HAVE MEDICARE COVERAGE OR ARE ELIGIBLE FOR MEDICARE PLEASE COMPLETE QUESTIONS BELOW:

Are you still working? Yes No Retirement Date: _____

Do you have an employer group health coverage? Yes No Number of Employees _____

Is your spouse still working? Yes No Retirement Date: _____

Are you covered through your spouse's insurance? Yes No Number of Employees _____

The signature below serves as authorization for medical treatment by the physician, physician's assistant, nurse practitioner, or nurse for the named patient. It also provides authorization for this Memorial Health University Physician to furnish and/or release any information necessary to insurance carriers, third party administrators, self-insured plan administrator, and/or other health benefit payer representatives in order to process health care claims incurred at this office or for utilization review or quality assurance.

GUARDIAN SIGNATURE _____ DATE _____