Insurance Information

Patient Name:_____

Medicaid: ID #_____ Sequence #: _____

Medicare #:_____ Effective Date: ___/___/___

Medicare Advantage Plan: _____ Policy #:_____

I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Adm. or its carriers, any information required to process my Medicare Claim.

Primary Insurance:_____ Policy #:_____

Address:_____ Group #:_____ Plan Code: _____

Subscriber:_____ Subscriber's Date of Birth: _____

Secondary Insurance:_____ Policy #:_____

Address:_____ Group #:_____ Plan Code: _____

Subscriber:_____ Subscriber's Date of Birth: _____

Tertiary Insurance:_____ Policy #: _____

Address:_____ Group #:_____ Plan Code: _____

Subscriber:_____ Subscriber's Date of Birth: _____

No Fault/ DOA: _____

Compensation/ DOI: _____ WCB:_____

Insurance Co:_____Address:_____

Employer:_____ Phone:_____

Address:_____

I hereby authorize **Costello Eye Physicians and Surgeons, PLLC** to release medical information necessary for filing claims for services rendered to the insurance companies listed above. I hereby authorize the insurance companies listed above to make payment of benefits directly to **Costello Eye Physicians and Surgeons, PLLC** for services rendered. I understand I am financially responsible for any charges not covered by my insurance or Medicare. I permit photocopies of this form to be valid as the original.

*** **Patient's Signature:**_____ Date:_____

For copying purposes, please give your insurance I.D. card to the secretary.