Allegheny Podiatry Management, L.L.C.
INSURANCE INFORMATION

This form is for the insurance department. We need this information so we can process all insurance claims.

A. PATIENT: This section refers to the PATIENT only:

Marital Status (Please Circle) Single Married Widow Divorced Separated

NAME _____Soc. Sec #_____

EMPLOYER _____

EMPLOYER ADDRESS _____

PCP Name _____ Phone # _____

B. BILLING: Please complete if holder of insurance is different than above patient.

NAME of who HOLDS Insurance _____ Soc. Sec. # _____

Address _____ _ Date of Birth _____

Home Phone # _____ Work Phone # _____ Cell Phone #_____

Employer's Name & Address _____

C. INSURANCE: Please give us all pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, please supply the information of both carriers.

1. PRIMARY INSURANCE CO _____

ADDRESS if not list on insurance Card_____

Person who HOLDS insurance_____ Relationship_____

ID#_____ Insured's Date of Birth_____

2. SECONDARY INSURANCE CO _____

ADDRESS if not listed on insurance Card_____

Person who HOLDS insurance_____ Relationship_____

ID#_____ Insured's Date of Birth_____

SIGNATURE ON FILE: In order to submit a claim for payment to us or for reimbursement to you for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

I hereby authorize a physician of Allegheny Podiatry Management to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by Allegheny Podiatry and DIRECT MY INSURANCE CARRIER OR ITS INTERMEDIARIES TO ISSUE PAYMENT CHECK(S) DIRECTLY TO ALLEGHENY PODIATRY MANAGEMENT for services I did not pay for. I understand I am financially responsible to Allegheny Podiatry Management for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

x_____ _____
Patient Signature Date