# CHANGE OF/NEW INSURANCE FORM

It is important that we have complete insurance information to assure that claims can be processed quickly and correctly.

**Name of Insurance Company** _____

**Group #** _____ **Subscriber #** _____

**Effective Date** _____ **Termination Date** _____
(new ins) (old ins)

Is there a secondary insurance? _____
( If yes, need same information)

The following information is on the *POLICYHOLDER* of the insurance, not the patient.

**Name of policyholder** _____ **/Relationship** _____

**Date of birth** _____ **Home #** _____

**Address** _____

_____

**Employer** _____ **Work #** _____

*CHILDREN* seen in this practice who are covered under this policy

**Name** _____ **/DOB** _____

_____ _____

_____ _____

*PRIMARY CARE PHYSICIAN* _____

I authorize the payment of insurance benefits to the party accepting assignment. The insurance information furnished represents a full disclosure of the benefits to which I am entitled. I understand that failure to disclose relevant information or providing false/inaccurate information for all plans under which I receive benefits, may result in non-payment by any insurance carrier, and I would incur full liability for all associated charges.

_____ _____
Signature Date