INSURANCE SIGNATURE FORM

PEDIATRIC EYE CARE
of MARYLAND

Patient Name: ______________________________ D.O.B. __________

Patient Soc. Sec. No.: _____-_______-_______

Name of Primary Insurance Co.: ______________________________

Policy Number: ____________________ Group Number: ____________

Name of Policy Holder: ______________________________

Policy Holder's Soc. Sec. No.: _____-_______-_______

Relation to Patient: ______________ D.O.B. of Policy Holder: __________

Policy Holder's Mailing Address: ______________________________

Name of Secondary Insurance Co.: ______________________________

Policy Number: _________________ Group Number: ______________

Name of Policy Holder: ______________________ D.O.B.: __________

RELEASE OF INFORMATION / PAYMENT AUTHORIZATION

I authorize release of any medical information from Pediatric Eye Care of Maryland to process insurance claims on my behalf. I authorize payment of medical benefits directly to the physician or supplier for myself and/or dependents as listed above. I certify that the information I have reported with regard to my insurance coverage is correct. I understand I am responsible for any deductibles, co-insurance/ or amounts for services not covered by the insurance carrier.

Date: ____________ Signature: ______________________________

FOR OFFICE USE ONLY

Pat #: ________ Date Entered: _______ Int: ______

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