INSURANCE SIGNATURE FORM

PEDIATRIC EYE CARE
of MARYLAND

Patient Name: _____D.O.B. _____

Name of Primary Insurance Co.: _____

Name of Policy Holder: _____

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

Relation to Patient: _____D.O.B. of Policy Holder: _____

*Policy Holder's Mailing Address:_____

* Only if changed or different from Patient's Address

Name of Secondary Insurance Co.:_____

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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