Thomas Badin MD Inc

INSURANCE INFORMATION

Primary Insurance:
Insurance Company Name:_____

Billing Address:_____
Street City State Zip
Phone Number:(_____)_____ Certificate/ID#:_____Group#:_____

IPA Group:_____Plan:_____Effective Date:_____/_____/_____

Copay Amount_____Urgent Care Copay Amount_____

Subscriber Name if different than Patient:_____

Subscribers Date of Birth_____ Relationship to Patient:_____

Subscriber's address:_____
Street City State Zip

Secondary Insurance:
Insurance Company Name:_____

Billing Address:_____
Street City State Zip
Phone Number:(_____)_____ Certificate/ID#:_____Group#:_____

IPA Group:_____Plan:_____Effective Date:_____/_____/_____

Copay Amount_____Urgent Care Copay Amount_____

Subscriber Name if different than Patient:_____

Subscribers Date of Birth_____ Relationship to Patient:_____

Subscriber's address:_____
Street City State Zip

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS:

I hereby authorize and request the insurance company(s), or agent thereof, to pay directly to Thomas Badin MD Inc. for services provided to me by Thomas Badin, MD.

I am aware that I am financially responsible for charges not covered by this assignment. I authorize refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

This signature will also serve as an authorization to release medical information necessary to satisfy payment.

_____ _____
Signature of Patient (If minor, signature of responsible party) Date

_____ _____
Print Patient Name Patient Date of Birth