

PARENTING ON CALL

AUTHORIZATION TO BILL INSURANCE

INSURANCE INFORMATION:

Primary Insurance Company: _____ ID Policy #: _____

Group #: _____ CoPay: _____ Deductible: _____

Claims Address: _____

Phone #: _____ - _____ - _____

Policy holder's Name: _____ Date of Birth: ____/____/____

Effective Date of Insurance: ____/____/____

Policy Holder's Employer: _____

Phone #: _____ - _____ - _____

Name of patient: _____

Patient Relationship to Insured: ___Self ___Spouse ___Child ___Other

Person Responsible for Account: ___Patient ___Parent ___Other: _____

Patient Date of Birth: ____/____/____

Patient Address: _____ Phone # _____ - _____ - _____

Secondary Insurance Company: _____ ID Policy # _____

Policy Holder Name: _____

Date of birth: ____/____/____

AUTHORIZATION TO BILL INSURANCE:

Patient or Authorized person's signature: I authorize Availity and/or Simple Practice, LLC to submit claims on my behalf. I authorize the release of any medical or other information necessary to process my claims.

Signed _____ Date _____