ParentingONCALL
Compassion. Results. Harmony.

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_____