HEARING REHABILITATION CENTER
INSURANCE INFORMATION

PRIMARY INSURANCE CARD INFORMATION

PRIMARY INSURED'S NAME: _____ ___ _____
FIRST INITIAL LAST

ADDRESS OF INSURED: _____ **CITY:** _____ **ZIP CODE:** _____

PATIENT RELATION TO INSURED: **SELF SPOUSE CHILD OTHER** **INSURED DATE OF BIRTH:** _____

INSURED EMPLOYMENT STATUS: **FULLTIME PARTTIME RETIRED** **SOCIAL SECURITY #** _____ - ____ - _____

INSURED EMPLOYER: _____ **WORK #**_____

INSURANCE COMPANY NAME: _____

SECONDARY INSURANCE CARD INFORMATION

PRIMARY INSURED'S NAME: _____ ___ _____
FIRST INITIAL LAST

ADDRESS OF INSURED: _____ **CITY:** _____ **ZIPCODE:** _____

PATIENT RELATION TO INSURED: **SELF SPOUSE CHILD OTHER** **INSURED DATE OF BIRTH:** _____

INSURED EMPLOYMENT STATUS: **FULLTIME PARTTIME RETIRED**

INSURED EMPLOYER: _____ **WORK #**_____

INSURANCE COMPANY NAME: _____

INSURANCE AUTHORIZATION

INSURANCE ASSIGNMENT AND RELEASE

I CERTIFY THAT I HAVE INSURANCE COVERAGE WITH THE ENCLOSED COPIES OF INSURANCE CARDS AND ASSIGN DIRECTLY TO DR. SOTIROPOULOS ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS.
THE ABOVE NAMED DOCTOR MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE-NAMED INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

MEDICARE AUTHORIZATION

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS AND, IF APPLICABLE, MEDIGAP BENEFITS, BE MADE EITHER TO ME OR ON MY BEHALF TO DR. SOTIROPOULOS , THE HEARING REHABILITATION CENTER FOR ANY SERVICES FURNISHED TO ME BY THAT PROVIDER. TO THE EXTENT PERMITTED BY LAW, I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, MY MEDIGAP INSURER, AND THEIR AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS FOR RELATED SERVICES.

SIGNED: _____ DATE: _____