

CHANGE OF INSURANCE FORM

Patient Name & Date of birth: _____

Insured Name & Date of birth: _____

Insurance Company: _____

Plan Type (HMO, PPO, POS, EPO, etc): _____

Claims Address: _____

Insurance Phone Number: _____

Policy ID: _____

Group ID: _____

Copay/Coinsurance/Deductible: _____

Primary Care Physician (PCP): _____

Please be advised that it is the responsibility of the insured to provide our office with ALL of the information requested above in order for us to file claims on your behalf to your insurance company. If we do not receive all of this information within 24 hrs of your visit, we will not be able to file the claim for you. In the event that you cannot provide us with this information you will be required to pay for your visit in full and we will provide you with an itemized receipt so that you may file your claim to your insurance company for reimbursement.

We apologize for any inconvenience this may cause. Thank you for your cooperation in this matter. If you have any questions you may ask to speak to someone in our billing office and they will be happy to assist you.

Willow Bend Pediatrics
Billing Department