PEDIATRIC associates

Date _____

INSURANCE CHANGE FORM

Children (seen as patients):

First Name	MI	Last name	Date of birth
First Name	MI	Last name	Date of birth
First Name	MI	Last name	Date of birth
First Name	MI	Last name	Date of birth

INSURANCE INFORMATION:

Primary Insurance:

Name of Plan | Subscriber ID# | Group# | Effective date

Subscribers name | Date of Birth | Employer

Subscriber's relationship to patient: ☐ Mother ☐ Father ☐ Self ☐ Other (explain):_____

Secondary Insurance:

Name of Plan | Subscriber ID# | Group# | Effective date

Subscribers name | Date of Birth | Employer

Subscriber's relationship to patient: ☐ Mother ☐ Father ☐ Self ☐ Other (explain):_____

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance company. A copy of this signature is as valid as the original.

Signature | Printed name | Relationship | Date