



Insurance Authorization

ACCOUNT # _____

Signing this document will allow Children's Medicine, P.C. to file your insurance for you. It will also allow your insurance company to send check(s) directly to Children's Medicine, P.C.

- I authorize the release of any information necessary to process this claim.
- I authorize payment of medical benefits to go to Children's Medicine, P.C.
- I understand that my insurance company does not cover a service, I will be responsible for payment.
- I have read and understand the "Fees and Payment Policies".

Parent or Guardian Signature Date

The above signature was witnessed by _____
Staff Member Signature

Date

Please list all patients covered on this policy:

Patient Name _____ Date of Birth _____
Patient Name _____ Date of Birth _____
Patient Name _____ Date of Birth _____
Patient Name _____ Date of Birth _____

Full Name of Insured _____

Insured's Social Security Number _____

Full Name of Insurance Company _____

Id/Policy/Member Number _____

Group Number _____

Date of Birth of Father _____ Date of birth of Mother _____