Rosemary Delgado M.D.

INSURANCE VERIFICATION FORM

Please take a few minutes to complete this form. All information provided is completely confidential. Thank you. We use this information only for medical insurance verification and billing.

PATIENT NAME _____ DATE _____

_____ I am insured under my own plan _____ I am insured under someone else's plan

DATE COVERAGE EFFECTIVE _____

NAME OF POLICY HOLDER _____

DATE OF BIRTH OF POLICY HOLDER _____

INSURANCE COMPANY NAME _____

ID NUMBER _____ GROUP NUMBER _____

CLAIM FILING ADDRESS _____

ZIP _____ CITY _____ STATE _____

PROVIDER BILLING PH. # _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

By signing below, I authorize Rosemary Delgado, M.D. To furnish all necessary information to my insurance carrier(s) concerning my medical care and treatment. I also irrevocably assign to the doctor all insurance payments for medical services rendered and all major benefits. I understand that I am personally obligated to pay for all medical services rendered, regardless of whether or how much my insurance company has paid.

NAME _____ DATE _____

SIGNATURE _____