MONTEREY PENINSULA PEDIATRIC MEDICAL GROUP

INSURANCE INFORMATION FORM

Do you or the patient currently have Central California Alliance for Health? (circle one) Yes No

Do you or the patient currently have a State of California Medi-Cal policy? (circle one) Yes No

Do you plan to add the patient to a Central California Alliance for Health policy? (circle one) Yes No

Name of Primary Insurance Company: _____

Primary Insured's Name:_____ Employer:_____

Primary Insured's SS#:_____ Primary Insured's DOB:_____

Policy/Member ID#:_____ Group#:_____

Relationship to Patient (circle one): Self Mother Father Other (please specify):_____

Name of Secondary Insurance Company: _____

Secondary Insured's Name:_____ Employer:_____

Secondary Insured's SS#:_____ Secondary Insured's DOB:_____

Policy/Member ID#:_____ Group#:_____

Relationship to Patient (circle one): Self Mother Father Other (please specify):_____

Patient's Name:_____ Patient DOB:_____

Patient's Name:_____ Patient DOB:_____

Patient's Name:_____ Patient DOB:_____

Patient's Name:_____ Patient DOB:_____

I authorize the release of any information necessary to process insurance claims and to obtain reimbursement. I request that payment of authorized benefits be made on my behalf to Monterey Peninsula Pediatric Medical Group (MPPMG). This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges not paid by my insurance.

X_____ _____

Signature of Guarantor **Date**

_____

Name of Patient