

## INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME

PHONE NUMBER

INSURANCE ADDRESS

NAME OF INSURED

RELATIONSHIP TO PATIENT

POLICY ID NUMBER

POLICY GROUP NUMBER

IS THIS A COBRA POLICY?  Y  N

DO YOU HAVE SEPARATE PRESCRIPTION BENEFITS?  Y  N

SECONDARY INSURANCE COMPANY NAME

PHONE NUMBER

INSURANCE ADDRESS

NAME OF INSURED

RELATIONSHIP TO PATIENT

POLICY ID NUMBER

POLICY GROUP NUMBER

IS THIS A COBRA POLICY?  Y  N

DO YOU HAVE SEPARATE PRESCRIPTION BENEFITS?  Y  N

## SIGNATURE ON FILE

### MEDICARE

BENEFICIARY NAME

MEDICARE INS. CLAIM #

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Medical Oncology Hematology Consultants, PA for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to CMS (Centers for Medicare and Medicaid Services) and its' agents any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE

DATE

### OTHER INSURANCE

I authorize my Insurance Benefits to be paid directly to Medical Oncology Hematology Consultants, PA. I authorize release of medical information to insurance companies in order for payment to be made. I understand that I am financially responsible for any balance due.

SIGNATURE

DATE

### PERSON RESPONSIBLE FOR THE BILL OTHER THAN PATIENT:

NAME

PHONE

ADDRESS