

Insurance Information:

Name of First Company to Bill: _____

Address: _____

Phone Number: _____ Policy Holder Name: _____ DOB: _____

Insured's ID Number (Medicare ID#, Medicaid ID#, etc.): _____

Policy Group Number: _____ Effective Date: _____

Relationship of Insured to Patient: Self Spouse Child Other

Name of Employer: _____

Name of Second Company to Bill (Secondary): _____

Address: _____

Phone Number: _____ Policy Holder Name: _____ DOB: _____

Policy Group Number: _____ Effective Date: _____

Relationship of Insured to Patient: Self Spouse Child Other

Name of Employer: _____

Workers' Compensation:

Name of Insurance Company: _____

Address: _____

Contact or Claim #: _____ Contact: _____ Phone: _____

If workers' comp claim, name of employer at time of accident: _____

Date of Accident: _____

Details of Accident/Injury: _____

Patient's Signature:

I verify the accuracy of the above information.

_____ Date: _____

PATIENT (OR AUTHORIZED) SIGNATURE

Patients should realize that professional services are provided to the person, not to an insurance company. Thus, the insurance company is responsible to the patient, and the patient is responsible to Virginia Prosthetics, Inc. We cannot render services on the assumption that the charges will be paid by an insurance company.

I have read and understand that Virginia Prosthetics, Inc. may bill my insurance company but this DOES NOT GUARANTEE BENEFITS. I understand that Virginia Prosthetics, Inc. will bill me directly for all supplies and services not covered by my insurance. I understand that these supplies are not returnable once I have removed them from the premises.

_____ Date: _____

PATIENT (OR AUTHORIZED) SIGNATURE