Registration Form for Insurance Billing

Please Print Clearly Thank-You

Date_____

Name: Last_____First _____Middle Initial_____

Street_____

City_____State_____Zip Code_____

Referring Doctor/PCP_____

Home Phone_____Work Phone_____Mobile Phone_____

Date of Birth _____SS#_____Sex: M___F___

Marital Status: Married _____Single___Divorced___

Primary Insurance Company: _____

Member ID No._____Group No._____

Patient Relationship to Insured: Self_____ Spouse_____ Child_____ Other_____

Name of Primary Insured:_____D.O.B. _____

Diagnosis _____Code # _____

I authorize any holder of medical or any other information about me to be released to the social security administration and the centers for Medicare and Medicaid services or its intermediaries or carriers, or to the billing agent of this provider, any information needed for this or a related medical claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to me or to the party who accepts assignment.

If your insurance company fails to pay for your services, you will be responsible for payment.

Signed_____ **Date**_____

Date:
Faxing:_____Pages
Ins. Reg.
ID
One Claim

From:

Maryann Meade & Associates
53Oakdale Circle
Wallingford, CT 06492
Updated 09/13
