PRIMARY INSURANCE INFORMATION

(If insured is different than patient or guarantor please include DOB)

Insurance Company:_____ **ID#**_____

Group#:_____

Copay Amount: $_____ **Effective Date of Insurance:** _____

Subscriber Name: _____ **DOB:** _____

Sex: M F Relation to Patient: _____ **SS#**_____

Address if different from patient: _____

City:_____**State:** _____ **Zip:**_____

Phone #: _____ **Other Phone #:** _____**Relationship to Patient:** _____

Subscriber employer: _____

SECONDARY INSURANCE INFORMATION

Insurance: _____ **ID#:** _____**Group#:**_____

Copay Amount $_____ **Effective Date:** _____

Subscriber's Name: _____ **Date of Birth** _____

Subscriber's Employer_____ **Relationship to Patient:** _____

I hereby authorize my insurance carrier to pay directly to Lovitt Gynecology & Women's Health, realizing I am responsible to pay non-covered services and hereby authorize the release of pertinent medical information to my insurance carrier.

Signature

_____**Date**_____

_____**Date**_____

Signature of Parent/ Guardian if patient is under the age of 18