MidState
PULMONARY

Breathe. Sleep. Heal.

Primary Insurance:

Name of Company: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Subscriber Name: _____ Relationship: _____

Subscriber's SS#: _____ Subscriber's DOB: _____

Insurance ID#: _____ Group#: _____

Secondary Insurance:

Name of Company: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Subscriber Name: _____ Relationship: _____

Subscriber's SS#: _____ Subscriber's DOB: _____

Insurance ID#: _____ Group#: _____

Does your insurance require a referral? ☐ **Yes** ☐ **No** **If yes, do you have one for today's visit?** ☐ **Yes** ☐ **No**

If my insurance carrier requires a referral and one is not obtained, I understand that I am responsible for payment of services rendered.

Signature: _____ **Date**: _____

Assignment of Benefits: I certify that the information given by me is correct. I hereby authorize payment to MidState Pulmonary of the insurance benefits payable to me. In applying for payment under Title XVIII or Title XIX of the Social Security Act, I request payment for authorized benefits that are made on my behalf to those who accept assignment. I further understand that I am responsible for any charges not covered or payable by this assignment.

Signature: _____ **Date**: _____

Authorization to Release Information: I hereby authorize any holder of medical information about me to release to my insurance carrier(s) or sponsoring agency(s) or DME company(s) as needed or to the Social Security Administration or its intermediaries or carriers, when relevant, information requested by them and needed for processing of benefit claims. I understand that I may revoke this authorization at any time.

Signature: _____ **Date**: _____

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PEACOCK ▪ CARPENTER ▪ CAPIZZI ▪ TYSON ▪ PRITCHETT ▪ ATWATER ▪ FERRELL ▪ BURK ▪ KHA ▪ WIGGER
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