NORTH TEXAS PERINATAL ASSOCIATES, P.A.

Maternal Fetal Medicine

INSURANCE VERIFICATION

PRIMARY INSURANCE INFORMATION *(Please print and complete this section in full.)*

Patient Name: ____ Date: ______________

Insured's Name: ______________________________ Insured's DOB: __________ Relationship to Insured: ____________________

ID Number / SS Number: ______________________________ Group / Employer: ______________________________

Insurance: ____ Phone: (_____) ________________

Claims Address: ____

Effective Date: ____________ Deductible: $ ____________ Amount Met: $ ____________ Co-Pay: $ ____________ Co-Ins: % ____________

Plan Type: HMO________ PPO ________ POS ________ EPO ________ Insurance Referral /Authorization Required: Yes ________ No ________

Referral / Authorization Number: ____ Staff Initial: __________

ASSIGNMENT OF BENEFITS

All patients are expected to pay by check, cash, MasterCard or Visa at time of visit. Co-pay's are due at time of service. You must present your insurance card at time of service or you will be responsible for payment in full. You are responsible for obtaining your referrals if required by your insurance company. We must have referrals on the day of your appointment. We will be glad to assist you in this process.

Texas Insurance Laws require claims to be paid in 45 days. We would appreciate your assistance in making sure your carrier meets their contracted deadline. We will make every effort to assist you with any appeals or claim denials. We cannot guarantee payment of your claims. If your claim is denied, you are ultimately responsible for payment in full.

Account statements are sent out monthly. Co-Insurance is due upon receipt unless a financial contract has been approved. **Please Note: We do not file secondary insurance.**

I understand and agree to abide by the above policies. I authorize release of medical information to process my claims for payment to the physician listed on my claim.

Signature of Insured or Authorized Person: ____ Date: ______________