ESSEX SPECIALIZED SURGICAL INSTITUTE
PATIENT AND INSURANCE INFORMATION

THE SURGERY CENTER REQUIRES THE FOLLOWING INFORMATION SO WE CAN FILE YOUR INSURANCE CLAIM(S). ALL CLAIMS ARE PROCESSED ACCORDING TO THE PATIENT'S PARTICULAR PLAN. DEDUCTIBLES, CO-INSURANCE, AND NON-COVERED SERVICES MAY APPLY AND ARE THE RESPONSIBILITY OF THE PATIENT.

PLEASE PRINT OR TYPE

NAME OF SURGEON: _____ DATE OF SERVICE: _____

PATIENT NAME: _____ DATE: _____

DATE OF BIRTH: _____ SEX: _____ SOCIAL SECURITY #: _____

HOME ADDRESS: _____

HOME PHONE #: _____

BUSINESS PHONE #: _____ CELL PHONE #: _____

PROCEDURE(S): _____ EYE: _____

PROCEDURE CODE: _____ DX CODE: _____

PRIMARY CARE PHYSICIAN

NAME: _____
PHONE #: _____
FAX #: _____

EMERGENCY CONTACT

NAME: _____
PHONE #: _____
RELATIONSHIP: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____
ADDRESS: _____

IDENTIFICATION #: _____ GROUP #: _____

POLICY HOLDERS NAME: _____ RELATIONSHIP: _____
POLICY HOLDERS DATE OF BIRTH: _____ SS#: _____

PRE CERT/AUTH #: _____

SECONDARY INSURANCE COMPANY: _____
ADDRESS: _____

IDENTIFICATION #: _____ GROUP #: _____

POLICY HOLDERS NAME: _____ RELATIONSHIP: _____
POLICY HOLDERS DATE OF BIRTH: _____ SS#: _____

PRE CERT/AUTH #: _____

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE AND/OR OTHER INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO ESSEX SPECIALIZED SURGICAL INSTITUTE FOR ANY SERVICES FURNISHED BY THIS SUPPLIER.

I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS AND/OR TO ANY OTHER INSRUANCE CARRIER(S) ANY INFORMATION NEEDED TO DETERMINE THE BENEFITS PAYABLE FOR RELATED SERVICES. THE ABOVE APPLIES TO THE ANESTHESIA PHYSICIAN AND THE MEDICAL CLEARANCE PHYSICIAN IF APPLICABLE.

PATIENT SIGNATURE _____ DATE _____

TRANSPORATION NEEDED: □ NO □ YES