Center For Pediatric Medicine *Our Family Caring For Yours*

CHANGE OF INFORMATION

Patient Name_____ Today's Date_____

D.O.B._____

Please complete the section that applies to you

CHANGE OF ADDRESS/PHONE NUMBER

New Address_____

_____

New Phone Number_____

CHANGE OF PRIMARY INSURANCE *(Please complete back of form for Change of Secondary Insurance)*

Date Your Old Insurance Expired_____

Name of New Insurance Company_____

Date New Insurance Became Effective_____ Co-Pay Amount $_____

Your Child's Member I.D. Number_____

Name of Primary Insurance Card Holder_____ D.O.B._____

Address of Primary Insurance Card Holder_____

_____

Name of Employer:_____ Employer's Phone #_____

Employer's Address_____

Group Name_____ Group Number_____

Claim Center Address (on the back of your card)_____

_____

By signing below, I certify that the information supplied on this form is correct.

_____ _____

Signature of Patient or Authorized Representative Date

Please Note: Your insurance company has given us a time limit for submitting your claim. If you do not have your insurance card with you today, please call our business office and give them your insurance information as soon as possible. Delay in supplying us with information may result in a denial of the claim, making you responsible for payment.

Thank you!

CHANGE OF SECONDARY INSURANCE

Date Your Old Insurance Expired_____

Name of New Insurance Company_____

Date New Insurance Became Effective_____ Co-Pay Amount $_____

Your Child's Member I.D. Number_____

Name of Primary Insurance Card Holder_____ D.O.B._____

Address of Primary Insurance Card Holder_____

_____

Name of Employer:_____ Employer's Phone #_____

Employer's Address_____

Group Name_____ Group Number_____

Claim Center Address (on the back of your card)_____

_____