Northeast Surgical Group, P.C.

Patient Insurance Information

☐ **I AM WITHOUT HEALTH INSURANCE COVERAGE (please confirm payment arrangements)**

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MEDICARE PATIENTS: please refer to your Medicare card and complete this section:

I, _____ Medicare # _____ request payment of authorized Medicare benefits be made on my behalf, to Dr. Michael J. Christofis, Dr. Michael J. D'Almeida, Dr. Roy E. Hanks, Dr. James H. McQuiston, Dr. Douglas G. Paulk and/or Dr. Corie L. Seelbach for services rendered. I authorize the release of my medical information to the Health Care Financing Administration and its agents if needed to determine these benefits payable.

MEDICARE PART A, effective date: _____ PART B, effective date: _____

☐ **I HAVE MEDICARE ONLY AND NO OTHER TYPE OF HEALTH CARE INSURANCE**

☐ **MEDICARE IS MY PRIMARY COVERAGE (secondary coverage listed below)**

☐ **MEDICARE IS MY SECONDARY COVERAGE (primary coverage listed below)**

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Primary Insurance (other than Medicare):

Insurance Name _____ Phone (_____)_____

Insurance address _____

Subscriber Name _____Birth date ___/___/_____ Contract #_____

Group # _____ Subscriber's Employer _____ Phone#_____

Your relationship to the subscriber: SELF SPOUSE DEPENDENT(child) OTHER :_____

>>>Is this a network insurance plan? HMO PPO OTHER: _____

>>>Do you require a referral for your office visits / treatment? **NO** **YES** *(If yes, you are responsible for obtaining the referral from your primary care physician and providing the referral at the time of your visit)*

>>>Primary Care Physician name: _____Phone (_____)_____

***Copay for office visit: $_____ *(payment of same is expected at time of service)*

****

Secondary Insurance (other than Medicare):

Insurance Name _____ Phone (_____)_____

Insurance address _____

Subscriber Name _____Birth date ___/___/_____ Contract #_____

Group # _____ Subscriber's Employer _____ Phone#_____

Your relationship to the subscriber: SELF SPOUSE DEPENDENT(child) OTHER :_____

>>>Is this a network insurance plan? HMO PPO OTHER: _____

>>>Do you require a referral for your office visits / treatment? **NO** **YES** *(If yes, you are responsible for obtaining the referral from your primary care physician and providing the referral at the time of your visit)*

>>>Primary Care Physician name: _____Phone (_____)_____

***Copay for office visit: $_____ *(payment of same is expected at time of service)*

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I authorize use of this form for all insurance submissions. I authorize release of my protected health information to all of my insurance companies, as indicated above. I authorize my physician to act as my agent in obtaining payment from my insurance companies. I authorize payment directly to the physician. I understand that I am ultimately responsible for my bill. I permit a copy of this authorization to be used in place of the original.

My signature below verifies that the information provided on this document is accurate as of today's date:

Patient's PRINTED name: _____ Date of Birth: _____

_____ _____

SIGNATURE OF: ***(PLEASE CIRCLE)*** Patient / Parent / Legal Guardian / Patient Advocate Date

17375 Hall Road, Macomb, MI 48044 *** Telephone 586-228-0550 ***Fax 586-228-8830

Northeast Surgical Group, P.C.

Patient Insurance Information: Part 2

If you have Medicaid, complete this section:

>>>Please be advised that we do not participate with Medicaid or any Medicaid HMO plans for elective services, and only accept Medicaid IF you are a Medicare Primary recipient or receive emergent treatment.

Medicaid Recipient ID number_____

Are you enrolled in a network plan through Medicaid? **NO YES = If yes, please provide the following:**

Name of Network Insurance Plan _____

Address _____ Phone (_____)_____-_____

Primary Care Physician _____ Phone (_____)_____-_____

>>It is your responsibility to obtain and provide a referral from your primary care physician for all services.

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WORKERS COMPENSATION: If the reason for your visit is related to an INJURY THAT OCCURRED AT YOUR PLACE OF EMPLOYMENT, <u>your health insurance is not responsible AND will not pay your claim</u>. You and your employer must provide us with the following information:

DATE OF INJURY:_____ DESCRIBE HOW THE INJURY OCCURRED:_____

_____

EMPLOYER_____ADDRESS_____
CITY STATE ZIP

CONTACT PERSON _____ Phone (_____)_____-_____

WORKERS COMP INSURANCE COMPANY:_____

BILLING ADDRESS:_____
CITY STATE ZIP

CONTACT PERSON AT THE INSURANCE COMPANY_____

PHONE# (____)_____ FAX# (____)_____

***CLAIM NUMBER _____**

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AUTOMOBILE INSURANCE: If the reason for your visit is related to an AUTO ACCIDENT, please provide the following:

Date of Accident _____ Auto Insurance Name _____

Address_____Phone (_____)_____

Policy # _____ Name of policy holder _____

***CLAIM NUMBER _____**

****

I authorize use of this form for all insurance submissions. I authorize release of my protected health information to all of my insurance companies, as indicated above. I authorize my physician to act as my agent in obtaining payment from my insurance companies. I authorize payment directly to the physician. I understand that I am ultimately responsible for my bill. I permit a copy of this authorization to be used in place of the original.

My signature below verifies that the information provided on this document is accurate as of today's date:

Patient's PRINTED name: _____ Date of Birth: _____

_____ _____

SIGNATURE OF: ***(PLEASE CIRCLE)*** Patient / Parent / Legal Guardian / Patient Advocate Date