THE HAND & WRIST CENTER

PATIENT NAME: ______________________________ **TODAY'S DATE:** ____________

***SECONDARY* INSURANCE TYPE AND NAME:**

☐ CASH-PAY ☐ PPO ☐ OUT OF NETWORK ☐ *WORKERS' COMP. ☐ MEDICARE ☐ HMO ☐ OTHER

INSURANCE NAME: ______________________ **CONTACT PERSON:** ______________

ADDRESS: ____

CITY: ______________________ STATE: __________ ZIP CODE:____________

PHONE: (________) ________________ FAX: (________)________________

NAME OF INSURED: ______________________ **INSURED'S DATE OF BIRTH:** __________

YOUR RELATIONSHIP TO INSURED: (circle one) SELF SPOUSE CHILD OTHER: ______________

INSURED'S SOCIAL SECURITY NUMBER or SUBSCRIBER I.D#: ______________________

PLAN GROUP NO.: ________________

DATE OF YOUR INJURY/ SYMPTOMS ONSET: ______________________

*WORKERS' COMP CLAIM NO.: ______________________

***TERTIARY (THIRD)* INSURANCE TYPE AND NAME:**

☐ CASH-PAY ☐ PPO ☐ OUT OF NETWORK ☐ *WORKERS' COMP. ☐ MEDICARE ☐ HMO ☐ OTHER

INSURANCE NAME: ______________________ **CONTACT PERSON:** ______________

ADDRESS: ____

CITY: ______________________ STATE: __________ ZIP CODE:____________

PHONE: (________) ________________ FAX: (________)________________

NAME OF INSURED: ______________________ **INSURED'S DATE OF BIRTH:** __________

YOUR RELATIONSHIP TO INSURED: (circle one) SELF SPOUSE CHILD OTHER: ______________

INSURED'S SOCIAL SECURITY NUMBER or SUBSCRIBER I.D#: ______________________

PLAN GROUP NO.: ________________

DATE OF YOUR INJURY/ SYMPTOMS ONSET: ______________________

*WORKERS' COMP CLAIM NO.: ______________________

➔ **NOTE: IF YOU HAVE MORE THAN THREE INSURANCE PLANS, PLEASE SPEAK WITH OUR STAFF.**

MULTIPLE INSURANCE PLANS DISCLAIMER: Please note that you (or the insured) are responsible for ensuring that the correct "Coordination of Benefits" is in effect at all times when multiple insurance policies are active. Coordination of Benefits relates to the order in which multiple plans pay benefits for your medical treatment. You are responsible for informing our office which plan is primary, secondary, etc. from your initial visit and throughout your entire care. **If you (the patient) fail to inform our office of the correct insurance order and/or an error is discovered relating to your Coordination of Benefits, we reserve the right to refuse to bill multiple insurance plans on your behalf.**

PATIENT SIGNATURE: ______________________________ **DATE:** ____________