Middle Tennessee Pulmonary
Insurance Information

Primary Insurance:

Name of Company:____________________________________Phone:____________________________

Address:____

City:____State:___________________Zip:_____________

Subscriber's name:______________________________Relationship:_____________________________

Subscriber's SS#:________________________________Subscriber's DOB:_________________________

Insurance ID#:__________________________________Group #:_________________________________

Secondary Insurance:

Name of Company:_____________________________________Phone:____________________________

Adress:____

City:____State:____________________Zip:____________

Subscriber
Name:____Relationship:______________________________

Subscriber SS#:__________________________________Subscriber's DOB:__________________________

Insurance ID#___________________________________Group #:__________________________________

Does your insurance require referral___Yes___NO If yes, do you have one for today's visit?___Yes__NO

If my insurance carrier requires a referral and one is not obtained, I understand that I am responsible for payment of services rendered.

Signature:____Date:___________________________

Assignment of Benefits: Icertify that the information given by me is correct. I hereby authorize payment to Middle TN Pulmonary of the insurance benefits payable to me. In applying for payment under Title XVIII or Title XIX of the Social Security Act, I request payment for authorized benefits that are made on my behalf to those who accept assignment. I further understand that I am responsible for any charges not covered or payable by this assignment.

Signature:____Date:________________________________

Authorization to Release Information: I hereby authorize any holder of medical information about me to release to my insurance carrier(s) or sponsoring agency(s) or DME company as needed or to the Social Security Administration or its intermediaries or carriers, when relevant, information requested by them and needed for processing of benefit claims. I understand that I may revoke this authorization at anytime.

Signature____Date:_____________________________________