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Health Insurance Information

Please fill out this form completely to ensure timely processing of your health insurance claim. If you have any questions, please contact the office.

Patient Information

Last Name *

Date of Birth *

MM/DD/YYYY

Primary Insurance Information

If you are a new patient, have new health insurance, or your health insurance has changed, please enter your updated insurance information.

Primary Insurance Name *

Example: Blue Cross, United Healthcare, Medicare, Medicaid, etc.

Member ID *

On your insurance card this may be labeled as your Member ID, ID#, Policy Number, Medicare Number, etc.

Group ID

If present on your Insurance Card

Insurance Card

Choose Image Nothing selected

Take a picture of your insurance card with good light on a smooth background. This helps make sure that your information is accurate and reduces delays. Image size must be less than 10MB.

Patient's Relationship to Policyholder *

-- Please Select --

Policyholder's First Name *

Policyholder's Middle Initial

Policyholder's Last Name *

Policyholder's Gender *

-- Please Select --

Policyholder's Date of Birth *

MM/DD/YYYY

Policyholder's SSN

Policyholder Address *

Policyholder Apartment/Suite/etc.

Policyholder City *

Policyholder State *

Policyholder ZIP Code *

Secondary Insurance Information

If you have another insurance (for example, through your spouse or employer) enter that information here. If not, leave blank and go to the next section.

Secondary Insurance Name

Example: Blue Cross, United Healthcare, Medicare, Medicaid, etc.

Member ID

On your insurance card, this may be labeled as your Member ID, ID#, Policy Number, Medicare Number, etc.

Group ID

Patient's Relationship to Policyholder

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Policyholder's First Name

Policyholder's Middle Initial

Policyholder's Last Name

Policyholder's Gender

-- Please Select --

Policyholder's Date of Birth

MM/DD/YYYY

Policyholder's SSN

Policyholder's Address

Policyholder's Apartment, Suite, etc.

Policyholder's City

Policyholder's State

Policyholder's ZIP Code

Medicare Questionnaire

If you filled out Medicare as your Primary or Secondary insurance, please fill out this section. Otherwise, answer No to the first question and leave the other questions blank.

Are you a Medicare beneficiary?*

- Yes
- No

Please answer Yes and complete the rest of this section if you are or may be eligible for Medicare.

Are you receiving Black Lung (BL) benefits?

- Yes
- No

If Yes, date benefits began:

MM/DD/YYYY

Are the services today to be paid for by a government research program?

- Yes
- No

Are you entitled to benefits through the Department of Veterans Affairs (DVA)?

- Yes
- No

If yes, has the DVA authorized and agreed to pay for your care at this facility?

- Yes
- No

Is your illness/injury due to a work-related accident?

- Yes
- No

If yes, please provide accident information to our staff.

Is your illness/injury due to a non-work-related accident?

- Yes
- No

If yes, please provide accident information to our staff.

Are you entitled to Medicare based on age?

- Yes
- No

Are you entitled to Medicare based on Disability?

- Yes
- No

re you entitled to Medicare based on End-Stage Renal Disease (ESRD)?

- Yes
- No

Are you currently employed?

- Yes
- Yes, but retired from previous employment

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- ( ) No, never employed

If Yes, Employer Name:

Do you have group health coverage through your current employer?

- ( ) Yes
- ( ) No

If yes, does your employer employ more than 20 people?

- ( ) Yes
- ( ) No

Do you have a spouse that is currently employed?

- ( ) Yes
- ( ) Yes, but retired from previous employment
- ( ) No, retired
- ( ) No, but not retired
- ( ) No, never employed
- ( ) No, not married

If yes, Spouse's Employer Name:

Do you have group health coverage through your spouse's current employer?

- ( ) Yes
- ( ) No

If yes, does your spouse's employer employ more than 20 people?

- ( ) Yes
- ( ) No

Health Insurance Information will be submitted to **COLLABORATEMD**

Submit

*You have **14** required fields to fill out. Click here to show them.*