

# The Arbor Center Insurance Form

Please fill out all the information below:

I hereby authorize The Arbor Center, PLC to apply for any benefits on my behalf for covered services rendered and request that the payment from my insurance company be made directly to The Arbor Center, PLC.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information including medical information for this or any related claim to The Arbor Center's billing agent and my insurance company.

I permit a copy of this authorization to be used in the place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

\_\_\_\_\_  
Signature of Subscriber or Beneficiary

\_\_\_\_\_  
Date

1. MEDICARE <input type="checkbox"/> (Medicare #)            MEDICAID <input type="checkbox"/> (Medicaid #)            TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN)            CHAMPVA <input type="checkbox"/> (Member ID#)            GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)            FECA BLK LUNG <input type="checkbox"/> (SSN)            OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY    SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
CITY	STATE	7. INSURED'S ADDRESS (No., Street)
ZIP CODE	TELEPHONE (Include Area Code) ( )	CITY
STATE	STATE	STATE
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	ZIP CODE
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO    PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	TELEPHONE (Include Area Code) ( )
a. OTHER INSURED'S POLICY OR GROUP NUMBER	11. INSURED'S POLICY GROUP OR FECA NUMBER	a. INSURED'S DATE OF BIRTH MM DD YY    SEX M <input type="checkbox"/> F <input type="checkbox"/>
b. OTHER INSURED'S DATE OF BIRTH MM DD YY    SEX M <input type="checkbox"/> F <input type="checkbox"/>	b. EMPLOYER'S NAME OR SCHOOL NAME	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. INSURANCE PLAN NAME OR PROGRAM NAME	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>
12. SIGNED _____	DATE _____	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____

PATIENT AND INSURED INFORMATION