

Insurance Information

Primary Insurance _____ Effective Date _____
Policy Number _____ Group Number _____
Name of Policy Holder _____
Subscriber Social Security # _____ Sex M F
Relationship of Patient to Policy Holder _____ Date of Birth of Insured _____
Employer of Subscriber _____ Telephone # _____
Address of Insurance _____
Street City State Zip
Co-Pay (Select One Only) Per: Visit Procedure Year Co-Pay \$ _____ / _____ %
(Indicate Amount/Percentage)

Secondary Insurance _____ Effective Date _____
Policy Number _____ Group Number _____
Name of Policy Holder _____
Subscriber Social Security # _____ Sex M F
Relationship of Patient to Policy Holder _____ Date of Birth of Insured _____
Employer of Subscriber _____ Telephone # _____
Address of Insurance _____
Street City State Zip
Co-Pay (Select One Only) Per: Visit Procedure Year Co-Pay \$ _____ / _____ %
(Indicate Amount/Percentage)

Tertiary Insurance _____ Effective Date _____
Policy Number _____ Group Number _____
Name of Policy Holder _____
Subscriber Social Security # _____ Sex M F
Relationship of Patient to Policy Holder _____ Date of Birth of Insured _____
Employer of Subscriber _____ Telephone # _____
Address of Insurance _____
Street City State Zip
Co-Pay (Select One Only) Per: Visit Procedure Year Co-Pay \$ _____ / _____ %
(Indicate Amount/Percentage)

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Insurance Information

MEDICARE PATIENTS ONLY

Medicare Signature on File

I request payment of authorized Medicare benefits be made on my behalf to Hearing Health Center, P.C. for any services furnished me by Hearing Health Center, P.C. I authorize any holder of medical information about me to release the information to the Centers for Medicare and Medicaid Services (CMS) and its agents in order to determine payable benefits for services rendered.

Signature _____ Date _____

Medicare Policy Number _____

Medigap Signature on File

(to be completed if you have secondary insurance in addition to Medicare)

Do you receive payment from the carrier when a medical claim is filed and then you pay the provider?

Yes No

I request payment of authorized Medigap be made on my behalf to Hearing Health Center, P.C. I authorize any holder of medical information about me to release to Centers for Medicare and Medicaid Services (CMS), it's agents and my Medigap or other insurance policy I have, any information needed to determine these benefits payable for related services.

Signature _____ Date _____

Medigap Carrier Name _____

Medigap Policy Number _____



Sparrow Professional Building

1200 E Michigan Ave, Suite 330 • Lansing, MI 48912 • 517.364.5678

Mason Community Health Center

800 East Columbia • Mason, MI 48854 • 517.244.8905

Clinton Memorial Physical Rehabilitation & Wellness Center

1079 S. US 27 (Southpoint Mall) • St. Johns, MI • 48879 • 989.224.1575

www.hearinghealthcenter.org

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