Columbus Pediatric Associates

Insurance Verification Form

Name and Date of Birth: _____Name and Date of Birth: _____

Name and Date of Birth: _____Name and Date of Birth: _____

Name of Insurance Company: _____

Claims Address: _____

ID#_____ Group#_____

Name of Subscriber: _____ Date of Birth: _____

Name of Subscriber Employer: _____ Copay amount $ _____

Relationship to child: _____

(If your child(ren) have a secondary insurance, or if you have a child(ren) that have other coverage different from that that you have listed above, please fill out the next section of this form.)

Secondary or other coverage information

Name and Date of Birth: _____ Name and Date of Birth: _____

Name of Insurance Company: _____

Claims address: _____

ID#_____ Group#_____

Name of Subscriber: _____ Date of Birth: _____

Name of Subscriber Employer: _____ Copay amount $_____

Relationship to child: _____

Please note that by filling out and signing this form you agree to the terms and conditions set forth by Columbus Pediatric Associates. We will attempt to file your insurance claims a Maximum of two times. If after this there is no resolution, the claim will be dropped to your responsibility to get you involved in getting your claims to pay. Please also make note that Columbus Pediatric Associates does not get involved in any custody issues. If you provide insurance information to be filed, we reserve the right to bill any and all parties responsible.

Parent/Guardian Signature: _____ Date: _____