

P.O. Box 780249 San Antonio, TX 78278-0249 | 800.388.8642 | Fax 210.492.1584 | order@ElectroLarynx.com

Medicare Champus Group Health Plan HMO

Primary Insurance (Card Number): _____

Secondary Insurance (Card Number): _____

[PLEASE SEND COPIES OF ALL INSURANCE CARDS- FRONT & BACK]

Patient Information

Patient's Name (Last/First/Middle Initial): _____

DOB _____ Marital Status _____ Patient's Sex: Male Female

Patient's Address (address, city, state, zip): _____

Phone: (____) _____

Patient's relationship to insured: _____

Home Hospice Hospital

Insured Information

Patient's Name (Last/First/Middle Initial): _____

Phone: (____) _____ DOB _____

Patient's or authorized person's signature. I authorize the release of any medical information necessary to process this claim. I also request payment of benefits either to myself or to the party who accepts assignment. I acknowledge my responsibility of any amount not covered by insurance.

Signed: _____ Date: _____

NAME & TELEPHONE NUMBER OF REFERRING PHYSICIAN OR OTHER SOURCE:

_____ UPIN _____