RMH BILLING

PATIENT CHANGE OF INFORMATION

Insurance Change: ☐ Address Change: ☐

Patient Name:_____ Patient Date of Birth: ____ /____ /_____

Patient Account # (if available): _____ Effective Date of Change: _____

Insurance Information

Primary Insurance: _____ Member/Subscriber #_____

Group # _____ Payer ID# _____ Phone: (____) ____-

Insurance Address: _____

Secondary Insurance: _____ Member/Subscriber #_____

Group # _____ Payer ID# _____ Phone: (____) ____-_____

Insurance Address: _____

Guarantor Information

(For insurance billing purposes, we require the name, date of birth, address if different than the patient, and employer name and phone number of the **person who is considered the insured**. This person is not always the patient and could be a spouse, parent, or another person.)

Guarantor Last Name: _____ First Name: _____ Middle Initial: _____

Guarantor Sex: M ☐ F ☐ Relationship to Patient: _____

Address (if different from patient): _____

City: _____ State: _____ Zip: _____

Guarantor SS #: _____-_____-_____ Guarantor Phone: (____)____-_____

Guarantor Date of Birth: ____ /____ /_____

Guarantor Employer: _____

Guarantor Email: _____

Address Information

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____)____-_____ Cell Phone: (____)____-_____ Work Phone: (____)____-_____

Email Address: _____