RMH BILLING

PATIENT INFORMATION SHEET

Provider Name _____ **Appointment Date** _____**Time**_____

Patient Information

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

Birth Date: _____/_____/_____ Patient SS #:_____ - _____ - _____ Sex: M ☐ F ☐

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: (____) ____ - _____

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

Email Address: _____

Additonal Contact: _____ Phone: (____) ____ - _____

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: _____

AUTHORIZATION TO PAY BENEFITS / RELEASE INFORMATION

I hereby authorize payment directly to the Provider of the medical benefits, if any, otherwise payable to me for his/her professional services rendered, realizing I am responsible for all non-covered services. I also authorize the release of the above provided information and any medical information necessary to: 1) provide for adequate professional coverage in the absence of the primary doctor, 2) to verify insurance coverage and 3) to file a claim for insurance benefits related to professional services rendered.

Patient Signature _____ Date _____

Responsible Party _____ Date _____

FOR OFFICE USE ONLY

Provider: _____ Patient Name/DOB_____

	In Network	Out of Network
DEDUCTIBLE	_____	_____
INSURANCE PAYS	_____	_____
COPAY/COINSURANCE	_____	_____
YEAR MAXIMUM	_____	_____
LIFETIME MAXIMUM	_____	_____

Contact/Date: _____

Deductible Met : _____

Out of Pocket Max / OOP Met: _____

Mailing Address:

_____

_____

NETWORK _____ ☐ IN ☐ OUT

Payer ID #_____

Ptn Notified _____

Precertification/Ongoing Cert Required? ☐ YES ☐ NO

Dr. Notified _____

MCO Name_____ Phone #_____Contact_____

Authorization #	# of Visits Auth'd	Date Range	CPT Code	Notes
_____	_____	_____	_____	_____