

INSURANCE POLICY

Our Managed Care insurance contracts require co-payments to be collected at the time of service.

It is the Patient's responsibility to give full & correct Insurance Information prior to the office visit.

For Patients with Worker's Compensation Insurance, it is the Patient's responsibility to give the following:

- 1. Employer's name & address**
- 2. Primary Care Physician's Name**
- 3. Referring Physicians's Name**
- 4. Date of Injury**
- 5. Whether or not you filed a report with your Employer**
- 6. Claim #**
- 7. Insurance Carrier Name**
- 8. Claim Address**
- 9. Adjustor's Name, phone # & fax #**
- 10. Nurse Case Manager Name, phone # & fax #**
- 11. Precertification phone #**

For Patients with Motor Vehicle related injuries, it is the Patient's responsibility to give the following:

- 1. Primary Care Physician's Name**
- 2. Referring Physician's Name**
- 3. Date of Injury**
- 4. Whether or not you filed an accident report**
- 5. Whether or not you have Med Pay with your auto insurance carrier.**
- 6. Whether or not you have exhausted your Med Pay benefits.**

IF THERE IS NO MED PAY OR IT IS EXHAUSTED, WE MUST HAVE A WRITTEN OR FAXED STATEMENT FROM THE AUTO INSURANCE CARRIER IN ORDER TO BILL A MEDICAL INSURANCE CARRIER.

- 7. Claim #**
- 8. Insurance Carrier Name**
- 9. Claim Address**
- 10. Adjustor's Name, phone # & fax #**

Please update our Receptionist with your current insurance, address, & phone # information. Please inform us of any changes to include your Primary Care Physician & Referring Physician.