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Change of Insurance Form

Today's Date _____

Patients Name	
Name of Old Insurance	
Termination Date of This Insurance	
Name of New Insurance Company	
Street Address	
City, State, Zip Code	
Claims Phone Number	
Effective Date	
Insurance ID	
Group Number	
Policy Holder Full Name	
Policy Holder Address	
Policy Holder Date of Birth	
Your Relationship to Policy Holder	Self Spouse Child

You are providing Insurance information to us so as a courtesy we can bill Your Insurance Company for you. You are required to know all of the above information. Remember, this is your Insurance not ours. If you do not know the answers to any of the above questions you **MUST** find them out and let us know. Remember it is YOUR obligation to provide us with **Complete, Accurate and Valid Insurance Information**. Insurance companies now have extremely short filing deadlines and follow-up deadlines for mistakes or lack of information. Incorrect information provided by you can have payment for your claim denied and you will then be responsible for payment of the bill. Please take the time to fill out the above information completely. Thank You

Patient Signature: _____

Print Patient Name _____

Checked and verified by _____