

GREENSPAN FAMILY EYECARE

Sheldon G. Greenspan, OD, PA

Adam D. Mark, OD

Troy Office Centre

1259 Rte 46E, Bldg 4B

Parsippany, NJ 07054

Phone# 973-263-9400

INSURANCE INFORMATION

PRIMARY INSURANCE

ADDITIONAL INSURANCE

Name of Insured _____

Name of Insured _____

Relationship to patient _____

Relationship to patient _____

Insured's birthdate _____

Insured's birthdate _____

Soc. Sec. # _____

Soc. Sec. # _____

Employer _____

Employer _____

Date Employed _____

Date Employed _____

INSURANCE COMPANY: _____

INSURANCE COMPANY: _____

Group # _____

Group # _____

SIGNATURE ON FILE

- I authorize use of this form on **all** my insurance submissions.
- I authorize release of information to all my **Insurance Companies**.
- I understand that **I am responsible** for my bill.
- I authorize my doctor to act as **my** agent in helping me obtain payment From my insurance companies.
- I authorize payment direct to my doctor.
- I permit a copy of this authorization to be used in place of the original.

Name (Please Print) _____ Medicare # _____

(if applicable)

Signature _____ Date _____

