

GREENSPAN FAMILY EYECARE

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INSURANCE INFORMATION

In order for us to bill in your behalf and collect payment from your insurance company, you must authorize us to do so by filling out this form completely and signing. Thank you

PRIMARY INSURANCE

Name of Primary Insured _____

Relation to Patient _____

Primary Insured's Birth Date _____

Soc. Sec.# _____

Insurance Co. _____

SECONDARY INSURANCE

Name of Primary Insured _____

Relation to Patient _____

Primary Insured's Birth Date _____

Soc. Sec.# _____

Insurance Co. _____

► **VERIFICATION OF BENEFITS OR COVERAGE *IS NOT* A
GUARANTEE OF ELIGIBILITY OR *PAYMENT*. ACTUAL PAYMENT IS
BASED ON TERMS AND CONDITIONS OF YOUR PLAN AT TIME OF
INSURANCE PROCESSING. ◀**

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 any balance after insurance processing.
- ✓ I authorize my doctor to act as my agent in helping me obtain payment from the insurance company.
- ✓ I authorize payment to be made directly to above mentioned doctors and/or practice.
- ✓ I permit a copy of this authorization to be used in place of the original.

Signature _____

Name (print) _____

Date _____