

PRIMARY VISION INSURANCE

SECONDARY VISION INSURANCE

Insurance Company: _____

Insurance Company: _____

Address: _____

Address: _____

Policyholder Information:

Policyholder Information:

Name: _____

Name: _____

Address: _____

Address: _____

ID/SSN: _____

ID/SSN: _____

DOB: ____/____/____

DOB: ____/____/____

Phone (H) _____

Phone (H) _____

(W) _____

(W) _____

Employer: _____

Employer: _____

Relationship to Policyholder _____

Relationship to Policyholder _____

PRIMARY MEDICAL INSURANCE

SECONDARY MEDICAL INSURANCE

Insurance Company: _____

Insurance Company: _____

Address: _____

Address: _____

Policyholder Information:

Policyholder Information:

Name: _____

Name: _____

Address: _____

Address: _____

ID/SSN: _____

ID/SSN: _____

DOB: ____/____/____

DOB: ____/____/____

Phone (H) _____

Phone (H) _____

(W) _____

(W) _____

Employer: _____

Employer: _____

Relationship to Policyholder _____

Relationship to Policyholder _____

I certify that the information given by me in applying for insurance and or/Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me to obtain payment of my insurance and or/Medicare benefits, and I authorize payment of these benefits directly to Grand Rapids Eye Care, LLP on my behalf for any services and/or materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine any benefits payable to related services. If I have other health insurance coverage (as indicated above and/or in Item 9 of the HFCA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Patient Signature (or person acting on patient's behalf)

Date