

CHANGE OF INSURANCE INFORMATION AND INSURANCE AUTHORIZATION

Patient Name: _____

Age _____ DOB _____

Cardholder Name _____	Cardholder DOB _____
Cardholder SSN: _____	Cardholder Phone _____
Cardholder Address _____	
Zip _____	
Covered Persons 1 _____	2 _____
3 _____	4 _____
5 _____	6 _____
7 _____	8 _____
Employer _____	Phone _____

INSURANCE COMPANY - PRIMARY	Phone _____
INSURANCE COMPANY NAME _____	Effective Date _____
Group Name: _____	Plan Number _____
Group Number : _____	Type* _____

INSURANCE COMPANY - SECONDARY	Phone _____
INSURANCE COMPANY NAME _____	Effective Date _____
Group Name: _____	Plan Number _____
Group Number : _____	Type* _____

INSURANCE COMPANY - TERTIARY	Phone _____
INSURANCE COMPANY NAME _____	Effective Date _____
Group Name: _____	Plan Number _____
Group Number : _____	Type* _____

* Type: G = General Medical W = Workman's Compensation M = Medicare MC= Medicaid

Insurance Authorization: I hereby authorize Lee Family Clinic d.b.a. University Medical Group to furnish information to my insurance carriers concerning illnesses of accidents for which claims for reimbursement are made on my behalf and hereby irrevocably assign to the attending physician all payments for medical services rendered by Lee Family Clinic d.b.a. University Medical Group's attending physician. I understand that I am financially responsible for all charges whether or not covered by insurance and that this authorization will be in effect until revoked by me.

Signature of Patient / Parent / Guardian / or responsible party

Date