

**INSURANCE CHANGE FORM
PATIENT INFORMATION**

PATIENT'S LAST NAME: _____ FIRST NAME: _____ MI: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____
SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

PRIMARY INSURANCE

POLICY HOLDER LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____
POLICY HOLDER DATE OF BIRTH: _____ POLICY HOLDERS SOCIAL SECURITY NO: _____
POLICY HOLDER GENDER: MALE FEMALE EFFECTIVE DATE: _____
POLICY HOLDER HOME PHONE: _____ POLICY HOLDER WORK PHONE: _____
POLICY HOLDER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
(If different from patient)
INSURANCE COMPANY: _____ OFFICE VISIT CO-PAY : _____
POLICY HOLDER EMPLOYER NAME: _____
POLICY HOLDER EMPLOYER ADDRESS: _____

SECONDARY INSURANCE

POLICY HOLDER LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____
POLICY HOLDER DATE OF BIRTH: _____ POLICY HOLDERS SOCIAL SECURITY NO: _____
POLICY HOLDER GENDER: MALE FEMALE EFFECTIVE DATE: _____
POLICY HOLDER HOME PHONE: _____ POLICY HOLDER WORK PHONE: _____
POLICY HOLDER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
(If different from patient)
INSURANCE COMPANY: _____ OFFICE VISIT CO-PAY : _____
POLICY HOLDER EMPLOYER NAME: _____
POLICY HOLDER EMPLOYER ADDRESS: _____

FAMILY PHYSICIANS OF O'FALLON, PC – ONLY

I understand my signature authorizes request for payment and release of medical information necessary to pay the claims for my health care. I understand that this medical information may contain confidential medical information protected by Federal Regulation [42 CFR, Part 2, 77III. Adm. Code 250.1510(a)(b)] and therefore by signature authorizes complete disclosure to my health insurance. If item 9 of HCFA Form 1500 (Paper or Electronic) is completed, my signature below authorizes releasing of the information to the insurer or agency shown on the front of this form. For MEDICARE and/or insurance companies with an assignment contract, the physician or supplier agrees to accept the charge determination of MEDICARE or my other insurance company as the full charge; and the patient is responsible only for the deductible and/or co-insurance based upon the charge determination of MEDICARE or my other insurance company. I understand that if I choose not to sign this statement I will pay cash for medical services rendered.

SIGNATURE: _____ **DATE:** _____