



# Colts Neck Pediatrics

Dr. Jocelyn Bautista / Dr. Carlene Navas

## Insurance Information – Assignment Authorization

**Effective Date:** \_\_\_\_\_

**Insured Dependent Name(s):**

- |                 |                            |
|-----------------|----------------------------|
| 1. First: _____ | Last (if different): _____ |
| 2. First: _____ | Last (if different): _____ |
| 3. First: _____ | Last (if different): _____ |
| 4. First: _____ | Last (if different): _____ |
| 5. First: _____ | Last (if different): _____ |
| 6. First: _____ | Last (if different): _____ |

**Insured's Information:**    New     Old

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

**Employer's Information:**    New     Old

Name of Employer: \_\_\_\_\_  
 Employer Phone #: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_  
 Insurance Co. Name: \_\_\_\_\_  
 Insurance Co. Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Please Read Below**

*I acknowledge that I have provided the above information to the best of my ability and that the patient(s) listed is(are) currently covered under the named insurance plan. I authorize all medical claims to be submitted to the insurance carrier and for payment to be made directly to Colts Neck Pediatrics. I also authorize the release of any medical information necessary to process a claim. I understand that I am responsible for any charges not covered or payable by the insurance carrier.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*If you have any questions regarding these policies and any insurance questions, please ask to speak with our billing staff/office manager. Thank you.*