Insurance Information Form

Patient ID Chart Number _____ Today's Date ____/_____/_____

Name of patient _____ DOB____/____/___
Address_____ Apt_____
City _____State_____ Zip Code_____
Phone Number (____) _____-_____

Name of AHCCCS Plan _____
AHCCCS ID Number _____
Do you have any insurance other than AHCCCS? **YES NO**

If you have AHCCCS and private insurance you are required to give Arizona Pediatric Clinics all information (initials)_____

Name of Private insurance _____
Insurance Phone Number (_____)-_____-_____ Effective Date___/___/___
Name of insured _____ DOB____/____/___
Insured Social Security number _____-____-_____
Insured ID Number _____Group Number _____
Relationship to patient _____

Name of Secondary Insurance _____
Insurance Phone Number (_____)-_____-_____ Effective Date___/___/___
Name of insured _____ DOB____/____/___
Insured Social Security number _____-____-_____
Insured ID Number _____Group Number _____
Relationship to patient _____

Is there a deductible? **YES-NO** If **YES** how much? $_____
Family or Individual deductible?
Has the deductible been met for this year 2009? **YES NO**
*****If NO the patient needs to pay for the visit up front*****
Is there co-insurance? **YES NO** If **YES** how much? _____%
What is the co-pay amount for sick visit? $_____
What is the co-pay amount for well child (Physical)? $_____
Does your insurance cover immunizations? **YES NO**

I have listed all current insurance information above. If there is a change in my insurance plan, I will inform Arizona Pediatric Clinics immediately. *(initials)*_____

Signature_____ Date____/____/_____