



MANCHESTER EAR, NOSE & THROAT, LLC INSURANCE INFORMATION

PATIENT NAME _____ DOB _____

NAME OF INSURANCE _____

POLICY # _____ GROUP # _____

POLICY HOLDER'S NAME _____ MALE FEMALE

POLICY HOLDER'S ADDRESS _____

POLICY HOLDER'S DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

WHAT IS YOUR COPAY FOR A SPECIALIST? _____

DOES YOUR INSURANCE REQUIRE A REFERRAL YES NO

FOR THE PURPOSE OF INFORMING US HOW WE SHOULD EXPECT PAYMENT, PLEASE ANSWER THESE QUESTIONS.

DO YOU HAVE A DEDUCTIBLE YES NO MONTH DEDUCTIBLE STARTS _____

HOW MUCH IS YOUR DEDUCTIBLE _____ HOW MUCH HAS BEEN MET _____

I understand that if I have a deductible, I am responsible for paying the allowed amount that the insurance may require for today's visit.

Signature

Date