

Primary Insurance Company	Secondary Insurance Company
Insurance Company Name: _____	Insurance Company Name: _____
Billing Address: _____ _____	Billing Address: _____ _____
Policy/Member Number: _____	Policy/Member Number: _____
Group Number: _____	Group Number: _____
Policy Holder's Name: _____ _____	Policy Holder's Name: _____ _____
Policy Holder's Social Security Number: _____	Policy Holder's Social Security Number: _____
Policy Holder's Date of Birth: ____/____/____	Policy Holder's Date of Birth: ____/____/____
Policy Holder's Place of Employment & Telephone Number: _____ _____	Policy Holder's Place of Employment & Telephone Number: _____ _____

Medicaid – Georgia Better Health - PeachCare
If Insurance is Medicaid or PeachCare please write ID# here _____ and complete the information requested below.
Person responsible for bill payment: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Telephone: _____ Work Telephone: _____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance and any other health plans to Monroe Pediatrics, Inc.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance, specifically telephone consultations, prescriptions and after hour visits. I hereby authorize assignee to release all information necessary to secure the payment.

Signed: _____ Date: ____/____/____