

# INSURANCE INFORMATION NEEDED TO FILE YOUR CHILDS INSURANCE – ROSWELL PEDIATRIC CENTER, P.C.

Parents without their child's current insurance card must complete this form. **All information must be included for us to file with your insurance.** If you are unsure of any information, please call your insurance company. Information may also be faxed to us. Our fax numbers are Crabapple Rd 770-343-8759, Old Milton Pkwy 770-751-7198, N. Corners Cumming 770-888-5562. **Otherwise, you will be responsible for all charges until all information is obtained or card is presented.** If your children are covered by different companies or you have more than one policy, please fill out a separate form for each insurance company and/or policy.

## **POLICY HOLDER INFORMATION:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_

Child's Name: \_\_\_\_\_ ID Number: \_\_\_\_\_

Child's Name: \_\_\_\_\_ ID Number: \_\_\_\_\_

Child's Name: \_\_\_\_\_ ID Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Effective Date of Insurance: \_\_\_\_\_

Copay: \$ \_\_\_\_\_ Deductible: \$ \_\_\_\_\_

Name of Current Insurance Company: \_\_\_\_\_

Plan Type: HMO / PPO / POS / EPO Other: \_\_\_\_\_

Phone Number of Insurance Company: \_\_\_\_\_

Claims Address: \_\_\_\_\_  
\_\_\_\_\_

Name of Previous Insurance: \_\_\_\_\_

Expiration Date of Previous Insurance: \_\_\_\_\_

## **FOR INTERNAL USE:**

- BCBS must have letters before policy #.  Aetna must have letters for policy #.  
 Please make sure we have all children's policy #'s NOT SOCIAL SECURITY NUMBERS.

FORM COMPLETE  FORM INCOMPLETE  Parent informed private pay until information provided and signed the "NO INSURANCE INFORMATION FORM"

Form accepted by (check-in): \_\_\_\_\_ Date: \_\_\_\_\_  
Signature

Insurance Entered by: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature