Electronic Claim Submission Enrollment Form

Primary Policy Holder Insurance Information

Name of Policy Holder____________________________Policy Holder Birthdate______________
Names of family members covered under this policy…
1.___________________________Relationship to Policy Holder___________________________
2.___________________________Relationship to Policy Holder___________________________
3.___________________________Relationship to Policy Holder___________________________
4.___________________________Relationship to Policy Holder___________________________
5.___________________________Relationship to Policy Holder___________________________
6.___________________________Relationship to Policy Holder___________________________
Name of Insurance Company____
Policy Number____________________ID or Certificate Number__________________________
Division Number (if applicable)_____________________
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Do you have coverage with more than one insurance company? YES_____ NO______

If yes, please complete the following…

Secondary Policy Holder Insurance Information

Name of Policy Holder_________________________ Policy Holder Birthdate________________
Names of family members covered under this policy…
1.___________________________Relationship to Policy Holder___________________________
2.___________________________Relationship to Policy Holder___________________________
3.___________________________Relationship to Policy Holder___________________________
4.___________________________Relationship to Policy Holder___________________________
5.___________________________Relationship to Policy Holder___________________________
6.___________________________Relationship to Policy Holder___________________________
Name of Insurance Company____
Policy Number____________________ID or Certificate Number__________________________
Division Number (if applicable)_____________________
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CONSENT FORM

I hereby authorize release, to my Insuring Company Plan Administrator, the information contained in claims submitted electronically.

____ _______________________________
Signature of Patient or Parent/Guardian Date