Blue Ridge Neuropsychological Associates

PATIENT INFORMATION AND AUTHORIZATION

Patient's Name _____

Address _____

City _____ State _____ Zip _____ Male ☐ Female ☐

Phone # _____ Date of Birth _____ Soc. Sec. # _____

I request that payment of authorized medical insurance (Medicare) benefits be made either to me or on my behalf to the above named provider for any services furnished me by the provider. I authorize the release of any medical information necessary to process insurance claims and any holder of medical information about me to release any such information needed to determine these benefits or the benefits payable for related services.

Patient's Signature _____ Date _____

INSURANCE INFORMATION

Attach copy of each insurance card

Medicare ID# _____ Medicaid ID# _____

Carolina Access Prov ID _____

Other Insurance Companies

ID # _____ Policy # _____

_____ _____

Insured's Name _____ Relationship to Insured _____

Insurance Company _____

Address _____

City _____ State _____ Zip _____

Other Insurance Companies

ID # _____ Policy # _____

_____ _____

Insured's Name _____ Relationship to Insured _____

Insurance Company _____

Address _____

City _____ State _____ Zip _____