



3425 First Avenue SE
Cedar Rapids, IA 52403
Phone: (319) 363-8572
Fax: (319) 297-7129

For Internal Use Only
Pt. No: _____

INSURANCE INFORMATION

Insurance card must be presented at the time of service for insurance to be filed.

Patient's Name: _____ Insurance Company Name: _____

ID/Policy Number: _____ Group Number/Group Name: _____

Subscribe Name: _____

Your Relationship to Subscriber: _____ Subscriber's Date of Birth: ____/____/____

Subscriber's Place of Employment: _____

INSURANCE AUTHORIZATION

I authorize the release of any medical information or other information necessary to process insurance claims on my behalf. I authorize payment of medical benefits to PPECI for services provided to me. I understand that I am financially responsible for all charges that my insurance company does not cover, including co-payments or deductibles. **I understand that I will be billed by PPECI to my authorized address and I agree to pay any balance owed.** I verify the above information is correct.

If you request a claim to be filed to your insurance, please be aware that a detailed description of charges will be sent to the policy holder (subscriber) list with the insurance company.

Signature

Date