HEALTH INSURANCE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Health Insurance Information

_____
Insured's Name

_____
Insurance Company

_____
Insurance Company Address City, State, Zip

_____
Insured's Employer

_____ _____ _____
Insured's Social Security Number ID Number Group Number

**A copy of your insurance card is required.

I authorize the release of my medical information or any other information that is relevant to my case to any insurance company or attorney for submitting claims and securing payment and reimbursement.

I understand that I am financially responsible for any charges that are or are not paid by my insurance provider.

_____ _____
Signature of Policy Holder or Responsible Party Date