Dr. Sarah Allen & Associates

Our Billing Company Must Have All of the Following Information In Order to Submit Claims on Your Behalf to Your Insurance Company:

Name of Primary Insured: _____ D.O.B. of Primary Insured: _____

Telephone Number & Address of Primary Insured: (____) _____

_____(City)_____(State)_____(Zip)_____

If Patient is a Dependent and not the Primary Insured Please Also Complete:

Name of Patient:_____ D.O.B. of Patient: _____

Telephone Number of Patient (if different): (_____)_____

Address of Patient (if different): _____

Insurance Information (found on your insurance card)

Insurance Co Name: _____

Address to file claims: _____ City/State: _____

Zip: _____ Telephone: _____

Subscriber ID of Primary Insured: _____ Plan/Group #: _____

I hereby authorize the release of any medical information necessary to process this insurance claim. I understand that an insurance company may not pay for services that they consider to be non-efficacious, not medically or therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services). In the event that my benefit was misquoted by my insurance company, I understand that it is still my responsibility to pay Dr. Sarah Allen & Associates.

Client Signature: _____ **Date:** _____