Your Choice®
Primary Care

Assignment of Insurance Benefits/Eligibility Certification

Primary Insurance Information		
Patient Name	Date of Birth	SSN
Insurance Plan	Policy/Member ID	Group/Account #
Effective Date	Customer Service Phone	Pre-Auth/Provider Phone
Policy Holder/Subscriber Name	Date of Birth	SSN
Relationship to Patient	Home Phone	Work Phone
Employer	Employer Address	

Secondary Insurance Information		
Patient Name	Date of Birth	SSN
Insurance Plan	Policy/Member ID	Group/Account #
Effective Date	Customer Service Phone	Pre-Auth/Provider Phone
Policy Holder/Subscriber Name	Date of Birth	SSN
Relationship to Patient	Home Phone	Work Phone
Employer	Employer Address	

For Medicare Patients Only		
Medicare Claim #	Part A Effective Date	Part B Effective Date

I hereby assign all medical and/or surgical benefits, to which I am entitled, including medicare, private insurance, and any other health plans to Your Choice Primary Care. This assignment is for services rendered to me by Your Choice Primary Care. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to the Social Security Administration, Health Care Financing Administration, its agents or carriers, or the insurance company to secure this payment. I understand that failure to notify Your Choice Primary Care of any changes of insurance coverage will result in the financial obligation to rest fully on myself regardless of any contract between the insurance company and Your Choice Primary Care.

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Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party Relationship to Patient