Andover Pediatrics

Please check one:

☐ New Patient Registration

☐ Update Info

- ✓ If all children in the family are on the **SAME** insurance policy – one form needed per family
- ✓ If children are on **DIFFERENT** plans – please complete a separate form for each child
- ✓ We'll need to **SCAN** your insurance card into the system with this form
- ✓ Please complete **BOTH SIDES** of this form and **SIGN** page 2!

PATIENT INFO

Child's First & Last Name	Date of Birth	Child's Insurance ID # MUST BE LISTED *	Suffix/Group #	PCP

Child's Address: _____ **Apt #**_____

_____

Subscriber / Guarantor Info: (*The parent that holds the insurance policy and will receive the bills*)

Relationship = Mother, Father, Grandmother, Foster Parent, etc

PRIMARY INSURANCE:

First & Last Name: _____

Subscriber Date of Birth: _____ **Relationship:** _____

Address: _____ **Apt #** _____

_____

Phone: _____

Email: _____

Do you have a SECONDARY Insurance Plan?

First & Last Name: _____

Subscriber Date of Birth: _____

Address: _____ **Apt #** _____

_____

Phone: _____

Email: _____

Other Parent / Guardian Info (if different from above)

NAME	Address	Phone	Date of Birth	Relationship

Insurance Billing Info

Insurance Company Info:

Ins Company Name / Plan Name: _____

Ins Co Billing Address: _____

_____

Ins Co Billing Phone: _____

Plan Effective Date: _____ **My Copay for primary care visits: $_____**

***** Please be sure to contact your insurance company and list us as your child's PCP – if we are not listed, they may not pay for visits!***

Consent for Billing:

- I have read the Notice of Privacy Rights detailing my rights. I understand that medical information obtained by Andover Pediatrics may be used for treatment, payment, quality assessments and case management.
- I understand that I am responsible for providing Andover Pediatrics and my insurance company with correct information to allow Andover Pediatrics to bill for services rendered for my child. I authorize payment of benefits due to be paid directly to Andover pediatrics. I also understand that there may be times when services will be provided which may or may not be a covered service and I accept full financial responsibility for these services.
- I understand that I am responsible for paying my copays and deductibles in following with my insurance plan agreement.

_____ _____ _____

Printed Name Signature Date