EPITOMEDICAL.

George Med-Peds Associates, P.C.
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Las Vegas, Nevada 89180-2227

# DUAL INSURANCE COORDINATION OF BENEFITS FORM

## PRIMARY INSURANCE INFORMATION

Patient Name: _____ Patient's Date of Birth: _____

Primary Insurance Company Name: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Policy Holder's SSN: _____ Policy Holder's Employer: _____

Policy Number: _____ Group Number: _____ ID Number: _____

To determine if other insurance coverage is seccondary to this plan, please complete the following information, sign, and date.

Are you or the patient covered by another insurance plan? ☐ Yes ☐ No If yes, please complete the following:

## SECONDARY INSURANCE INFORMATION

Secondary Insurance Company Name: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Policy Number: _____ Group Number: _____ ID Number: _____

Policy Effective Date: _____ Policy Holder's SSN: _____

Type of Coverage (check all that apply): ☐ Medical ☐ Dental

Is there a court order decree?: ☐ Yes ☐ No

If yes, does the decree specify which parent is responsible for providing medical/dental coverage for the child/children? Per your Medical insurance carrier, a copy of the Court Order Decree will need to be provided to your Medical office to submit insurance claims on your behalf. Failure to provide all required documents in a timely manner (30-90 days) will result in denial of the claims, and at which point the financial responsibility will belong to the patient/guardian.

- I, the undersigned, to hereby also give my permission to **George Med-Peds Associates, P.C.**, to furnish my insurance carrier(s) any and all information pertaining to my medical records.
- I certify that the above is true, correct, and complete.
- A copy of my signature is valid as the original.

Patient / Authorized Party Name **(Printed)**: _____

Patient / Authorized Party Signature: _____ Date: _____