Insurance Claim Submission

For your convenience, we can submit claims to your insurance company on your behalf. If we are not contracted with your insurance carrier or medical group, we will ask for payment at the time of service. **If you are unable to provide proof of insurance, you will be responsible for the entire bill on the date of service.**

Please fill out this form in its entirety, as all fields are required for proper claim submission. The form must be signed and returned to the business office or the front desk. **Make sure this form is filled out in its entirety. If not, you will receive a bill for the services rendered and the charges will be your responsibility. WE DO NOT BILL SECONDARY INSURANCE.**

If your insurance company fails to acknowledge receipt of the claim within 90 days, you are responsible for payment of the charges in full. Please be aware that you will need to carefully monitor your claims.

Any co-pays specified on your insurance card are due at the time of service. Failure to pay at the time of service will incur a $10.00 billing charge in addition to your co-pay. You will also be responsible for any co-insurance or deductible portions (if applicable) once the insurance processed the claim. We require 24-hour advance notification for cancelled appointments. Appointments not cancelled 24 hours in advance will incur a $75.00 "no show" fee.

Primary Insurance Coverage Information

Patient: _____ _____ _____ _____
(Last Name) (First Name) (MI) (Date of Birth)

Siblings: _____ _____ _____ _____

Siblings: _____ _____ _____ _____

Policy Holder's Name:_____

Policy Holder's Employer: _____

Insurance Company Name: _____

Claim Address: _____

_____

Group #: _____ Identification Number: _____

Effective Date of Coverage: _____

Parent's Name & DOB: _____ Parent's Name & DOB: _____
Gender: Ⓜ or Ⓕ Gender: Ⓜ or Ⓕ

Child's Primary Care Physician:_____

I authorize the release of any medical information necessary to process my insurance claims. I authorize payment of medical benefits to Golden Gate Pediatrics, A Medical Corporation, for medical services rendered. I also understand that I am fully responsible for any non-covered services, co-insurances, deductibles and co-pays per my insurance plan.

Patient Balance

Payment of the bill is the patient's responsibility and not that of the insurance company. A service charge of 1 1/2% per month will be made on balances due beyond 60 days. This represents an annual rate of 18%.

I have read and understand the policies above.

Signature: _____ Date: _____

Please Do Not Write Below This Line - For Office Use Only

Status	Date	Initials
Received		
Verified & Entered		
Returned for:		Date returned: