**Robert David Tufft MD**

# Insurance Information Form

Patient Name_____ Date of Birth_____-

Social Security # _____

Address_____

Address City_____ Address State_____

Primary Insurance (check): ( ) Medicare ( )PPO ( ) HMO ( )Workers Compensation ( ) MediCal

( ) Private Indemnity ( ) Medical Saving Acct

Secondary Insurance? ( ) Yes ( )No

Policy Information:

## Primary Insurance

**Policy Holder's Name**_____ Social Security #_____

Date of Birth_____ Relationship to Patient_____

Home Address_____

Employer's Address_____

Policy Holders Telephone # _____ Work #_____ Cell_____

Name of Primary Insurance Company _____

Policy # _____ Group # _____ Subscriber # _____

Mailing address for claims_____

Effective Date of Policy_____ Expiration Date _____

Policy Telephone #_____ Policy Limit_____

Policy Deductible_____ Policy Co-pay_____

Pre-authorization for services required? _____

## Secondary Insurance

**Policy Holder's Name**_____ Social Security #_____

Date of Birth_____ Relationship to Patient_____

Home Address_____

Employer's Address_____

Policy Holders Telephone # _____ Work #_____ Cell_____

Name of Primary Insurance Company _____

Policy # _____ Group # _____ Subscriber # _____

Mailing address for claims_____

Effective Date of Policy_____ Expiration Date _____

Policy Telephone #_____ Policy Limit_____

Policy Deductible_____ Policy Co-pay_____

Pre-authorization for services required? _____

**Tertiary Insurance: Please provide Details**_____

( ) I authorize Robert David Tufft MD (DBA Internists Medical Group) to release diagnosis and treatment information to my insurance company for the purpose of claim recovery and to authorize necessary care. I understand that if such information is not provided then the claim is my personal responsibility.

Signature_____