

Upstate Plastic Surgery
Insurance Information Sheet

If you are seeing our physicians today for anything other than cosmetic reasons we need to get your insurance information. Due to the changes in the insurance process it is very important that we receive the correct information before we see you. Please complete the form below, bring with you for appointment and turn in to the front desk with copy of card.

Patient Name: _____

Primary Insurance: _____ Phone #: _____

Policy Holder Name: _____ DOB: _____

Mailing address for Claims: _____

Policy #/ID#: _____ Group #: _____

Employer name _____ Phone#: _____

Secondary Insurance: _____ Phone #: _____

Policy Holder Name: _____ DOB: _____

Mailing address for claims: _____

Policy#/ID: _____ Group#: _____

For Insurance Cases: I hereby authorize Upstate Plastic Surgery to submit a claim to my insurance carrier or Medicare for COVERED SERVICES. I direct my insurance carrier to issue payment to Upstate Plastic Surgery. I further authorize the release of any medical information needed to process any insurance claim. I understand and agree that I am responsible for any amount not covered by my insurance carrier.

I also understand that if I do not provide to Upstate Plastic Surgery all information or the correct information to file my insurance claims that I will be responsible for the entire charge.

Signature: _____ Date: _____