Fair Oaks Women's Health
Obstetrics and Gynecology
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Fair Oaks Women's Health
Convenience • Caring • Cutting-Edge

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INSURANCE INFORMATION FORM

Please take a few minutes to complete this form. All information provided is completely confidential. Thank you. We use this information only for medical insurance verification and billing.

PATIENT NAME _____ DATE OF BIRTH _____

_____ I am insured under my own plan _____ I am insured under someone else's plan

INSURANCE COMPANY NAME _____

CLAIM FILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

BILLING PH# _____

NAME OF POLICY HOLDER (GUARANTOR): ☐ MYSELF or _____

MEMBER ID NUMBER of POLICY HOLDER _____

POLICY GROUP NUMBER _____

DATE POLICY ISSUED _____

DATE POLICY EXPIRES _____

CO-PAY AMOUNT (SPECIALISTS) _____

CO-INSURANCE PERCENTAGE _____

PRIMARY CARE PROVIDER _____

TYPE OF INSURANCE: ☐ INDEMNITY ☐ PPO ☐ POS ☐ EPO ☐ MEDICARE

RELEASE OF INFORMATION

By signing below, I authorize Fair Oaks Women's Health to furnish all necessary information to my insurance carrier(s) concerning my medical care and treatment.

NAME _____ DATE _____

SIGNATURE _____

Insurance Verification

_____

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