Chestnut Ridge
Pediatric Associates

Tel:(201) 252-8700
Fax: (201) 252-8701

An Affiliate Of
BCD
Health Partners

CHESTNUT RIDGE PEDIATRICS
Medical Insurance Information

Date: _____

Patient Name: _____

Insurance Name: _____ **ID #** _____

Address for Claim Submission: _____

_____

Group # _____ **CoPay:** _____

Effective Date: _____

Subscriber Name: _____ **Subscriber DOB:** _____

Subscriber Social Security # _____

Employer: _____

I hereby authorize Chestnut Ridge Pediatrics to release any medical or incidental information that may be necessary for medical care and in processing application for financial benefits.

I hereby authorize direct payment of medical benefits to Chestnut Ridge Pediatrics for services rendered by its doctors or persons under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

A photocopy of these assignments shall be as valid as the originals.

Printed Name: _____ **Date:** _____

Signature: _____