Health Insurance Claim Form

Member ID Number Group Number Name of Insurance

Name of Policy Holder (Last Name, First Name, Middle Initial):

Address of Person Listed Above (Include City, State, and Zip Code):

Insured's Date of Birth: ___ /___ /____ (MM/DD/YY) **Sex: M or F**

Employers Name:

_____

Is there any other Health Insurance? NO YES:

_____

Effective Date of this insurance: ___ (Month, Year)

Names of all members covered under this policy:

PLEASE SIGN BELOW

PATIENTS OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I authorize the payment of medical benefits to Northeast Colorado Family Medicine Associates, P.C.

Signed: _____ Date: ___ /___ /____