Western Fertility Institute

Patient Insurance Information:

Insurance Company_____ Phone Number_____

Identification Number_____ Group Number_____

Subscriber Name_____ Subscriber Date of Birth_____

Relationship to patient_____

Do you have secondary insurance? ☐ Yes ☐ No

Secondary Insurance Company:

Insurance Company_____ Phone Number_____

Identification Number_____ Group Number_____

Subscriber Name_____ Subscriber Date of Birth_____

Relationship to patient_____

Partner Information:

Insurance Company_____ Phone Number_____

Identification Number_____ Group Number_____

Subscriber Name_____ Subscriber Date of Birth_____

Relationship to patient_____

Do you have secondary insurance? ☐ Yes ☐ No

Secondary Insurance Company:

Insurance Company_____ Phone Number_____

Identification Number_____ Group Number_____

Subscriber Name_____ Subscriber Date of Birth_____

Relationship to patient_____

I certify that the insurance information on this form is true and correct . Should there be a change in my insurance information I will notify the office immediately. I understand that failure to supply insurance information in a timely manner can result in the denial of claims. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any services rendered.

Patient Signature: _____ Date: _____

Patient Signature: _____ Date: _____