

Medical PPO Billing Form

Dear Patient, Please fill out this form so that we may properly bill your medical ppo for this visit. Just a reminder: We are not a preferred provider on any medical plans. We will be happy to bill your insurance company for an eye infection or emergency. However if the plan does not pay for your visit(s) the balance is your responsibility. If your PPO pays a portion of your visit the balance is your responsibility as well. If you do not agree with this policy we cannot see you for your eye infection and/or emergency. We do not bill for HMO plans. Please sign here that you understand and agree to cover all unpaid expenses.

Patient Signature: _____

Date: _____

Name of Primary Insurance Plan: _____

Name of Member: _____

Members Date of Birth: _____

Members Employer Name: _____

ID #: _____

Group #: _____

Billing Address of PPO: _____

Address is often listed on the back of your card

Are you the: member or dependent ? Circle One

Patients Name: _____

Patients Date of Birth: _____

Patients Place of Employment or School: _____

If you have a Secondary Insurance Plan please ask the front desk for another form so that we may bill your insurance plans for you.

Medical PPO Secondary Plan

This is for all patients with a secondary plan to fill out so that we may bill your insurance plans for you. You must fill out the Primary Plan form first so that we have all of your appropriate information.

Name of PPO: _____

Billing Address: _____

Members Name: _____

Affiliation to Patient: _____

Parent, Spouse, Domestic Partner, Child

Members Date of Birth: _____

Members Place of Employment: _____

Members ID #: _____

Members Group #: _____

Is the primary insurance through the patient? _____