CONSULTANTS IN CARDIOLOGY & ELECTROPHYSIOLOGY LLC

3545 W 95th ST
Evergreen Park, IL. 60805
Phone 708-346-5562 Fax 708-346-2059

Date _____ MD who referred _____

Name: _____ ____/____/____
First Middle Last DOB

Address: _____ _____
Street Number Marital Status

_____ Phone# (1) _____
City State Zip

Phone# (2) _____

Employer: _____ Date Retired_____

Social Security: _____ Phone # _____
Address:

_____

Emergency contact _____ Phone #_____

OTHER INSURED INFORMATION

Name _____ DOB _____ Relationship _____

Address _____ City _____ State _____ Zip_____

Phone (____) _____ Social Security # _____ Marital Status_____

Employer _____
Occupation_____

Address _____ City _____ State _____ Zip _____

Phone (____) _____ # of employees at place of employment: <20 _____>20_____

INSURANCE INFORMATION

Primary Carrier: _____ ID#: _____ GR#:_____

Subscriber _____ Relationship _____

PPO ☐ HMO ☐ REFERRAL NEEDED ☐ YES ☐ NO Specialist Co-Pay amount $_____

Secondary Insurance _____ ID # _____ Gr. #_____

Subscriber _____ Relationship _____

PPO ☐ HMO ☐ REFERRAL NEEDED ☐ YES ☐ NO Specialist Co-Pay

Amount$_____

MEDICARE: Your claim will be filed automatically and our office reimbursed directly. We are a participating physician and assignment is accepted. If you have a Medigap policy as a secondary insurance, that will be filed also. Otherwise, payment of any deductible and/or co-insurance is due at the time of service.

_____ Initial

PPO: Insurance will be filed on your behalf. However, any co-payment and/or deductible is due at the time of service.

_____ Initial

HMO: Insurance will be filed on your behalf only if a Preauthorization Form from your primary physician is presented at the time of your visit. However, any co-payment and/or deductible is due at the time of service. If we do not have a Preauthorization Form and authorization cannot be obtained, payment in full for your visit is expected at the time of service.

_____ Initial

ALL OTHER INSURANCE: Payment in full is due at the time of service unless prior arrangements have been made with our office. We will provide you with a completed claim form in approximately one week from your visit which you can send directly to your carrier for reimbursement.

_____ Initial

Benefits vary and your insurance may pay all, some or none of your bill. Please become familiar with your insurance coverage, as you are responsible for paying any charges not covered by your carrier.

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PHYSICIANS ASSIGNMENT OF BENEFITS

AND AUTHORIZATON TO RELEASE INFORMATION

I hereby authorize the submitting physician to release any information acquired in the course of my examination or treatment necessary to process insurance claims.

I assign any benefits payable by my insurance carrier to the provider of services submitting a bill for services rendered.

X _____
Signature of Patient

X _____
Signature of Insured