In office use only: Date ___________ Card effective date ___________ Initials_______

Insurance Information

Please provide current insurance card for the receptionist to copy.

The Bozeman Clinic is contracted with the following insurance companies and will file your claim.

Medicare: ______ Blue Cross Advantage: _____ Blue Cross: ______ HMK (CHIPS)____ EBMS: ____
Pacific Source: ____ Allegiance: ______ Cigna: ______ Medicaid: ____ United HealthCare: ______

I am aware insurance companies have the right to request and review my medical information in order to process my medical claim(s).

I do not have insurance __________ I have Private Insurance not listed above___________________
(insurance name)

Patient Name: ____ DOB ____________

Insurance Subscriber Name: ______________________________

Subscriber information (this is needed if subscriber is not the patient):

Date of Birth: _________________ Phone #: ________________

Address: ____

City _____________ State__________ ZIP___________

Relationship to the Patient: _____________________

Does the Insurance information above apply to other family members who are patients in this office?

Yes ___ No ___ If yes, please list the family members:

____

____

Other Private Insurance: You will be given a copy of an itemized statement at the time of your visit. This copy can be used to file a claim. Reimbursement/explanation of benefits will be sent to you directly from the insurance company.

Payment Agreement

1) The person accompanying a minor is responsible for payment.
2) I understand that payment is required at the time of service.
3) I am prepared to pay by : Cash ____ Check ____ Credit Card (MasterCard, Visa, Discover, AMX) ______
4) ***I understand that should I default on payment of my account and collection agency services are required, all costs of collection including attorney and court costs will be added to the balance of my account.***

Signature: ____ Date: ____________________