The Business Side

Insurance Patient Registration Form

Anything with an asterisk is REQUIRED, or your VOB can NOT be completed!

PATIENT INFORMATION** **PLEASE PRINT CLEARLY OR FILL OUT VIA PDF VIEWER

*LEGAL Name (FIRST, LAST)_____

*Email (completed VOB will be sent here)_____

*Address_____

*City_____*State_____*Zip_____

*Best Contact Phone Number (Including Area Code)_____

*Birthdate (MM/DD/YYYY FORMAT)_____ Social Sec #_____

*Due Date _____ *First Pregnancy? ○YES ○NO

INSURANCE INFORMATION ***** ○PRIMARY ○SECONDARY ○TERTIARY

The front and back of your insurance card is required for VOB completion. If the patient is the subscriber, the subscriber can be left blank. If the subscriber is someone else, we cannot submit claims without the below information indicated with an asterisk. Social Security number is not required unless that is the member identification number, and not printed directly on the insurance card image.

*Subscriber's Name _____

*Subscriber's DOB_____ Subscriber's Social Sec#_____

*ID# on Card_____ Group#_____

*Patient's relationship to Subscriber: ○ Spouse ○ Child ○ Other:_____

THE FRONT AND BACK OF THE INSURANCE CARD ARE REQUIRED FOR VERIFICATION OF BENEFITS (VOB) COMPLETION

I certify that the information on this form is correct to the best of my knowledge. I authorize The Business Side to verify my insurance benefits on my behalf for the fee of $25, which I will pay upon invoice. I understand that if I have a SECONDARY insurance, I MUST complete another form and submit another payment of $25. I authorize my insurance company to make payment directly to my provider if claims are filed. I give my authorization to my provider and The Business Side to release any information necessary to process my benefits or insurance claims. I understand the final outcome for my insurance benefits and processing of my claims is under the discretion of the insurance company. I will not hold The Business Side nor my provider responsible for the information reported on this verification or the manner in which my claims process. I understand that I am financially responsible to make payment arrangements with my provider for balances owed in the event insurance does not cover services rendered.

EMAIL COMPLETED FORM TO: MARISSA@THEBUSINESSSIDEFL.COM. You will then receive your $25 invoice via email. The Business Side will obtain benefit information within 7 business days of paid invoice. PLEASE If a member's policy changes for <u>any</u> reason, please submit an updated patient registration form for a new VOB. Thank you!

Signature:**_____Date:**_____