Jeffrey M. Nelson, M.D.

(520) 575-8400

Insurance Information & Authorization

(Please Print Legibly & Sign)

Patient's Name _____
First Middle Last

Primary Insurance Company _____

Policyholder's Information:

Name _____ Birthdate ___/___/___

Employer _____ Relationship to Patient _____

Does this insurance require a referral? ❒ Yes ❒ No Copay Amount $ _____

Secondary Insurance Company _____

Policyholder's Information:

Name _____ Birthdate ___/___/___

Employer _____ Relationship to Patient _____

Does this insurance require a referral? ❒ Yes ❒ No Copay Amount $ _____

Is this visit due to any type of accident? ❒ No ❒ Yes: Date of Accident _____

Type of Accident ❒ Auto: State? _____ ❒ Work Related ❒ Other: _____

All Insurance Patients – Signature on File

I request that payment of authorized benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the above listed insurance companies and their agents any information needed to determine these benefits payable for related services.

Beneficiary Signature _____ Date _____

Medicare Patients Only – Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date _____

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