Ulster Medical and Surgical Specialists

150 Sawkill Road, Kingston, NY 12401 Phone: (845)750-6977 Fax:(845)750-6974

PATIENT'S NAME:_____ ACCOUNT#_____ DATE_____
FIRST MIDDLE LAST

STREET ADDRESS:_____

CITY:_____STATE:_____ZIP CODE:_____ SEX: M☐ F☐

EMPLOYER:_____ EMPLOYER ADDRESS:_____

HOME PHONE:_____ WORK PHONE:_____

EMERGENCY PHONE NUMBER AND NAME:_____

DATE OF BIRTH:_____ SS#:_____ MARITAL STATUS: S☐ M☐ D☐ W☐

REFERRING PHYSICIAN'S NAME & ADDRESS:_____

FAMILY PHYSICIAN'S NAME & ADDRESS:_____

SPOUSE'S EMPLOYER:_____

SPOUSE'S EMPLOYERS ADDRESS:_____

SPOUSE'S WORK PHONE #:_____

IF A MINOR, NAME OF PARENT OR GUARDIAN:_____

IN CASE OF AN EMERGENCY, CALL: NAME:_____PHONE#:_____RELATIONSHIP_____

IF YOUR INSURANCE CARRIER REQUIRES A REFERRAL/AUTHORIZATION FROM YOUR PRIMARY PHYSICIAN, YOU MUST PROVIDE ONE, I.E., CDPHP, MVP, WELLCARE, ETC.)

PRIMARY INSURANCE:_____

POLICY #:_____ GROUP #:_____

ADDRESS:_____TELEPHONE #:_____

RELATIONSHIP TO INSURED:_____

POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT):_____

SS# OF POLICY HOLDER (IF DIFFERENT FROM PATIENT):_____

DATE OF BIRTH OF POLICY HOLDER (IF DIFFERENT FROM PATIENT):_____

SECONDARY INSURANCE:_____

POLICY #:_____ GROUP #:_____

ADDRESS:_____TELEPHONE #:_____

RELATIONSHIP TO INSURED:_____

POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT):_____

SS# OF POLICY HOLDER (IF DIFFERENT FROM PATIENT):_____

DATE OF BIRTH OF POLICY HOLDER (IF DIFFERENT FROM PATIENT):_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize the release of any medical and/or other information necessary to process this claim. I also request payment of insurance benefits either to myself or **Ulster Medical and Surgical Specialists** should they elect to accept assignment, otherwise payment is due upon services.

SIGNED:_____

DATE:_____

MEDICARE ONLY

I authorize any holder of medical or any other information about me to release to the social security administration and the centers for Medicare and Medicaid services or its intermediaries or carriers, or to the billing agent of this physician, any information used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

SIGNED:_____

DATE:_____

MEDIGAP WAIVER

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the provider of service and/or supplier for any services furnished to me by the provider of service and/or supplier. I authorize any holder of Medicare information about me to release to my Medigap insurance:_____

_____,any information needed to determine these benefits payable for related services.

HIC# _____

SIGNED: _____

DATE: _____

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TURN OVER AND FILL OUT IF YOU WERE IN A CAR ACCIDENT OR HURT AT WORK