

## CHANGE OF INSURANCE FORM

**This information must be fully completed. If there is incorrect, erroneous or insufficient insurance information provided, this account will be considered Self-Pay.**

**The person carrying the insurance should be listed as the subscriber.**

**Patient Name:** \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_

**ID/Policy #:** \_\_\_\_\_

**Group #:** \_\_\_\_\_

**SS #:** \_\_\_\_\_

**Co-Payment Amount:** \_\_\_\_\_

**Subscriber Name:** \_\_\_\_\_

**Subscriber Date Of Birth:** \_\_\_\_\_

**Policy Effective Date:** \_\_\_\_\_

**Patient's Relation to Subscriber:** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

**ID/Policy #:** \_\_\_\_\_

**Group #:** \_\_\_\_\_

**SS #:** \_\_\_\_\_

**Co-Payment Amount:** \_\_\_\_\_

**Subscriber Name:** \_\_\_\_\_

**Subscriber Date of Birth:** \_\_\_\_\_

**Policy Effective Date:** \_\_\_\_\_

**Patient's Relation to Subscriber:** \_\_\_\_\_

Copy of Insurance Card is Required

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**Signature acknowledges the information provided is correct, true and current:**

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

Information reviewed: 07 \_\_ /08 \_\_ /09 \_\_ /10 \_\_ /11 \_\_ /12 \_\_ /13 \_\_ /14 \_\_ /15 \_\_ /16 \_\_ /17 \_\_ /18 \_\_