Southern Oregon Rheumatology Clinic

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NOTIFICATION OF PATIENT INSURANCE CHANGE

This form is to be used for the purpose of demographic and insurance changes only;
all other information from the original registration form is on file for your review and can be updated per your request

Patient Name *(Last, First, Middle)* _____ Date of Birth _____ XXX-XX- _____ Social Security #

PRIMARY INSURANCE

Patient's own insurance policy or spouse's if "not" employed

Name of Insurance: _____

ID#: _____ Group #: _____

Subscriber's Name: _____ Subscriber's SSN: _____

Relationship to Patient: _____ Subscriber's Birth Date: _____

Address (if different from patient): _____ Phone: ( ) _____

Subscriber's Employer: _____ Work Phone: ( ) _____

SECONDARY INSURANCE

*Are you covered by additional insurance? **If yes**, complete this section*

Name of Insurance: _____

ID#: _____ Group #: _____

Subscriber's Name: _____ Subscriber's SSN: _____

Relationship to Patient: _____ Subscriber's Birth Date: _____

Address (if different from patient): _____ Phone: ( ) _____

Subscriber's Employer: _____ Work Phone: ( ) _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits directly to my healthcare provider who accepts assignment. **I understand that I am financially responsible for all charges whether or not paid by insurance. I attest that the above information is true and correct to the best of my knowledge.**

Responsible Party Signature _____ Relationship to Patient _____ Date _____

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