

**INSURANCE INFORMATION NEEDED TO FILE YOUR CHILD'S
INSURANCE – Pediatric Associates of NYC, P.C.**

Parents without their child's current insurance card must complete this form. **All information must be included for us to file with your insurance.** If you are unsure of any information, please call your insurance company. **Otherwise, you will be responsible for all charges until all information is obtained or card is presented.** If your children are covered by different companies or you have more than one policy, please fill out a separate form for each insurance company and/or policy.

POLICY HOLDER INFORMATION:

Name: _____ Date of Birth: _____
Insurance ID#: _____ Policy: _____

Child's Name: _____ ID Number: _____
Child's Name: _____ ID Number: _____
Child's Name: _____ ID Number: _____
Child's Name: _____ ID Number: _____

Group Number: _____ Effective Date of Insurance: _____
Copay: \$ _____ Deductible: \$ _____

Plan Type: HMO / PPO / POS / EPO

Phone Number of Insurance Company: _____

Claims
Address: _____

Name of Previous Insurance: _____

Expiration Date of Previous Insurance: _____

FOR INTERNAL USE:

- BCBS must have letters before policy #. ? Aetna must have letters for policy #.
- Please make sure we have insurance ID #'s NOT SOCIAL SECURITY NUMBERS.

Form accepted by (check-in): _____ Date: _____