

SECONDARY INSURANCE COVERAGE

Secondary Insurance: _____

Claims Address: _____

City: _____ State: _____ Zip Code: _____ Phone: () _____

Responsible Party: Self Spouse Parent Other **Subscriber** _____

Patient's Relationship to Subscriber: Self Spouse Parent Child Dependent Other: _____

Subscriber's Address: _____

City: _____ State: _____ Zip Code: _____

Subscriber's Birthdate: _____ Social Security # _____ Phone () _____

Subscriber's Employer: _____

Work Phone() _____ **Extension** _____

Employer's Address:-- _____

City: _____ State: _____ Zip Code: _____

Effective Date of Insurance: _____ **Co-payment Amount:** _____

Policy #: _____ **Group #:** _____

Guarantor:

Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: () _____ Work Phone: () _____ Extension _____

Guarantor's Relationship to patient: Self Spouse Parent Child Dependent Other: _____

Guarantor's Employer:

Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: () _____ Work Phone: () _____ Extension _____

Allergies:

Reaction:

I certify that the demographic and insurance information provided above is current and accurate to the best of my knowledge. I authorize the release of any medical or other information necessary to process my claims. I authorize payment of medical benefits to GREATER BALTIMORE MEDICAL ASSOC. for services rendered to me.

Signature of Patient and/or Financially Responsible Party

Date