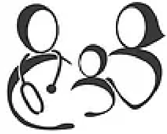

Pediatric Associates of Whidbey Island
Insurance Form

Child's Legal Name: ____________________________________ Birthdate: __________ Sex: ☐M ☐F ☐NB

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Child's Legal Name: ____________________________________ Birthdate: __________ Sex: ☐M ☐F ☐NB

****

Primary Insurance: ____

ID Number: ______________________________ Group Number: ______________________________

Subscriber's Name:___________________________________ Subscriber's Birthdate:_______________

****

Secondary Insurance: ____

ID Number: ______________________________ Group Number: ______________________________

Subscriber's Name:___________________________________ Subscriber's Birthdate:_______________

****

Tertiary Insurance: ____

ID Number: ______________________________ Group Number: ______________________________

Subscriber's Name:___________________________________ Subscriber's Birthdate:_______________

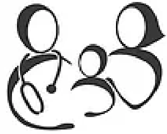
****

I hereby authorize *Pediatric Associatesof Whidbey Island* to release any medical or other information necessary in order to process insurance claims/billing on my behalf. I authorize payment directly to the doctor for any benefits available under my insurance. I hereby assign to the physician all payments for medical services rendered. I understand that I am responsible for all fees, regardless of insurance coverage.

<u>Co-payments must be paid at the time of service.</u>

Signature of Parent/Guardian (if patient is under age 18):

____ Date: _____________________



Pediatric Associates of Whidbey Island
Insurance Form

Apple Health

Child's Legal Name: ___________________________________ Birthdate: __________ Sex: ☐M ☐F ☐NB

Managed Care Plan (Circle One): **Molina** **Coordinated Care** **CHPW** **Amerigroup**

ID Number: ______________________________ Provider One Number: ______________________________

****

Child's Legal Name: ___________________________________ Birthdate: __________ Sex: ☐M ☐F ☐NB

Managed Care Plan (Circle One): **Molina** **Coordinated Care** **CHPW** **Amerigroup**

ID Number: ______________________________ Provider One Number: ______________________________

****

Child's Legal Name: ___________________________________ Birthdate: __________ Sex: ☐M ☐F ☐NB

Managed Care Plan (Circle One): **Molina** **Coordinated Care** **CHPW** **Amerigroup**

ID Number: ______________________________ Provider One Number: ______________________________

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Child's Legal Name: ___________________________________ Birthdate: __________ Sex: ☐M ☐F ☐NB

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ID Number: ______________________________ Provider One Number: ______________________________

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