Welcome to Kidsville Pediatrics

Insurance Authorization Form

Signature Is Required on Below Statements

Insurance Information: Please give card to receptionist to copy for our files

Insurance Company Name:_____
Policy Holder Name:_____
Policy Holder DOB:_____ SSN:_____
Policy Holder Relationship to Patient:_____

Policy Number:_____ Group Number:_____
Effective Date of Policy:_____

Assignment of Benefits: I hereby authorize direct payment of medical benefits to Kidsville Pediatrics PA for services rendered by the physician or person under his/her supervision. I understand that I am financially responsible for any balance not paid or not covered by my insurance policy, including co-payments and deductibles. Charges on statement are agreed to be correct unless protested in writing within 15 days.

I understand and agree to above statement:_____

Authorization to Release of Information: I hereby authorize Kidsville Pediatrics to release or obtain any medical or surgical information for either medical, processing applications for medical benefits, or information requested by my insurance company for processing of claims.

I understand and agree to above statement:_____

Medicaid Recipients: I certify that the information give by me in applying for payments is correct. I authorize release of all reports on request. I request that payment of authorized benefits be made directly to Kidsville Pediatrics PA

Patient Name (Print):_____ Date:_____

Parent / Guardian (Print):_____

Parent / Guardian Signature:_____