gileseyecare

1039 Washington Ave

Portland ME 04103

Medical and Vision Insurance Form

Patient's Name _____ Date _____

Medical Insurance

Primary Medical Insurance _____

Policy# _____ Group# _____

Subscriber's Name _____ Subscriber's Date of Birth _____

Patient's Relationship to Subscriber _____

Secondary Medical Insurance _____

Policy# _____ Group# _____

Subscriber's Name _____ Subscriber's Date of Birth _____

Patient's Relationship to Subscriber _____

Vision Insurance

Vision Insurance Name_____

Policy# _____ Group# _____

Subscriber's Name _____ Subscriber's Date of Birth _____

Patient's Relationship to Subscriber _____

I certify that the information given by me in applying for insurance payment is true and correct. I authorize Giles Eye Care to act as my agent in helping me obtain payment. I authorize payment of these benefits directly to Giles Eye Care on my behalf for any services or materials furnished. **I understand that I am responsible for payment of any co-pay, coinsurance, and/or deductible assessed by my insurance or any services/materials deemed "non-covered" by my insurance. Also, I understand that if my insurance (HMO) requires a referral or prior authorization for my office visit and I did not obtain one prior to my visit, I am responsible for payment of services if my insurance denies the claim.**

Signature _____ Date_____