Primary Insurance Company	**Secondary Insurance Company**
Insurance Company Name: _____ Billing Address: _____ _____ Policy/Member Number: _____ Group Number: _____ Policy Holder's Name: _____ _____ Policy Holder's Social Security Number: _____ Policy Holder's Date of Birth: _____/_____/_____ Policy Holder's Place of Employment & Telephone Number: _____ _____	Insurance Company Name: _____ Billing Address: _____ _____ Policy/Member Number: _____ Group Number: _____ Policy Holder's Name: _____ _____ Policy Holder's Social Security Number: _____ Policy Holder's Date of Birth: _____/_____/_____ Policy Holder's Place of Employment & Telephone Number: _____ _____

Medicaid – Georgia Better Health - PeachCare
If Insurance is Medicaid or PeachCare please write ID# here _____ and complete the information requested below. Person responsible for bill payment:_____ Address:_____ City:_____ State: _____ Zip Code: _____ Home Telephone:_____ Work Telephone:_____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance and any other health plans to Monroe Pediatrics, Inc.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance, specifically telephone consultations, prescriptions and after hour visits. I hereby authorize assignee to release all information necessary to secure the payment.

Signed: _____ Date: _____/_____/_____