NJ Ortho Group, LLC
INSURANCE INFORMATION

IS THIS INJURY WORK RELATED? Yes / No IS THIS INJURY MOTOR VEHICLE RELATED? Yes / No.

If Worker's Comp or MVA please fill out insurance information below:

INSURANCE COMPANY: _____ ADJUSTER / CASE WORKER: _____
TELEPHONE #: _____ ADDRESS: _____
CLAIM #: _____ ATTORNEY: _____
EMPLOYER: _____

In the event that my motor vehicle or workers comp insurance denies coverage for or does not authorize treatment for services provided by NJ Spine Group, LLC, I authorize all charges to be submitted to my private health insurance providing my health insurance is not an HMO or does not provide out of network benefits. I will then be personally responsible for all charges. In the event that I have no other health insurance coverage, I am aware that I am personally responsible for all charges for my care.

(Patient signature)_____

PRIMARY INSURANCE COVERAGE

TYPE OF COVERAGE: HMO POS PPO MEDICARE SCHOOL SELF PAY OTHER

NAME OF INSURANCE PLAN: _____

CLAIM ADDRESS: _____ CITY _____

STATE _____ ZIP CODE _____PHONE NUMBER _____

SUBSCRIBER'S NAME: _____ DATE OF BIRTH ____/____/_____

SEX: ____ Male ____ Female RELATIONSHIP TO PATIENT: _____

SUBSCRIBER INSURANCE ID #: _____GROUP # _____SUBSCRIBER SS#_____

SUBSCRIBER'S EMPLOYER NAME: _____ EFFECTIVE DATE _____

IS THE INSURANCE COVERAGE THROUGH THE SUBSCRIBER'S EMPLOYER? Yes / No

SECONDARY INSURANCE COVERAGE

TYPE OF COVERAGE: HMO POS PPO MEDICARE SCHOOL SELF PAY OTHER

NAME OF INSURANCE PLAN:_____

ADDRESS: _____ CITY _____

STATE _____ ZIP CODE _____ PHONE NUMBER _____

SUBSCRIBER'S NAME: _____SS#_____ DATE OF BIRTH ____/____/_____

SEX: ____ Male ____ Female RELATIONSHIP TO PATIENT: _____

SUBSCRIBER INSURANCE ID #: _____ GROUP # _____ EFFECTIVE DATE: ____/____/_____

SUBSCRIBER'S EMPLOYER NAME: _____

IS THE INSURANCE COVERAGE THROUGH THE SUBSCRIBER'S EMPLOYER? Yes / No