BCD Health Partners

160 Pehle Avenue, Suite 302
Saddle Brook, NJ 07663

TEL: (201) 252-8700
FAX: (201) 252-8701

WILLOWBROOK PEDIATRICS
Medical Insurance Information

Date: _____

Patient Name: _____

Insurance Name: _____ ID # _____

Address for Claim Submission:_____

_____

Group #: _____ CoPay: _____

Effective Date: _____

Subscriber Name:_____ Subscriber DOB _____

Employer:_____

I hereby authorize Willowbrook Pediatrics to release any medical or incidental information that may be necessary for medical care and in processing application for financial benefits.

I hereby authorize direct payment of medical benefits to Willowbrook Pediatrics for services rendered by its doctors or persons under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

A photocopy of these assignments shall be as valid as the originals.

Printed Name: _____ Date: _____

Signature: _____