

2010 LONG LAKE CAMP MEDICAL CENTER PATIENT INFORMATION FORM

Please sign the Assignment of Benefits and Release of Information below. This allows us to submit a claim for your child. **Enclose a copy (front and back) of your insurance card** and any pertinent insurance information we would need. Also send any claim form you feel are necessary for your situation.

CAMPER (FIRST)_____ (LAST) _____
CAMPER'S DATE OF BIRTH_____ (SEX) _____
PARENTS (FIRST)_____ (LAST) _____
ADDRESS _____
CITY_____ STATE _____ ZIP _____
INSURANCE CARRIER _____
SUBSCRIBERS NAME _____
SUBSCRIBERS DATE OF BIRTH_____ SS# _____
INSURANCE ID# _____ GROUP # _____
ADDRESS FOR CLAIMS TO BE SENT _____

ASSIGNMENT OF BENEFITS

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW.

SIGNATURE _____ **DATE** _____

RELEASE OF INFORMATION

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS TO THE PARTY THAT ACCEPTS ASSIGNMENTS BELOW.

SIGNATURE _____ **DATE** _____

PLEASE BE AWARE THAT YOU ARE RESPONSIBLE FOR ANY DEDUCTIBLE, NON-COVERED CHARGES OR MEDICINES.

PLEASE INCLUDE PHOTO COPY FRONT AND BACK OF YOUR INSURANCE ID CARD

FOR OFFICE USE ONLY
SESSION DATES _____