Surprise Pediatrics
Secondary Insurance Form

Patient Name: _____
Date of Birth: _____

As a courtesy to our patients, Surprise Pediatrics will bill secondary insurance with the understanding that it's the insured's responsibility to inform our office of the **correct** insurance information as stated below.

Please contact both insurance companies and inform them that you need "**COORDINATION OF BENEFITS"** as you have two insurances. They will then inform you as to whether they are your primary or secondary insurance company. If you can get written verification, please send us a copy. Otherwise, please document the following in the space below: date, customer service representative name, their phone number, and any reference number given.

_____
_____
_____
_____

Primary Insurance: _____
Subscriber Name and DOB: _____
Subscribed Identification #: _____
Group Number: _____
Effective Date: _____

Secondary Insurance: _____
Subscriber Name and DOB: _____
Subscribed Identification #: _____
Group Number: _____
Effective Date: _____

I, (print name)_____, understand that I am responsible for providing Surprise Pediatrics with the correct insurance information for primary and secondary billing. I also understand that if the above information is incorrect; that Surprise Pediatrics will no longer bill secondary insurance as a courtesy to me. It is also understood that I am responsible for any remaining balance not paid by my secondary insurance.

Signature: _____ Date: _____

NOTE: Claims will be held for three (3) business days to allow the insured party (ies) to coordinate benefits and return this form. If we do not receive this information after three (3) days, we will only bill one insurance company for the visit.

Date of service: _____

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