METROWEST PODIATRY SERVICES

42 LINCOLN STREET
FRAMINGHAM, MA 01702

INSURANCE VERIFICATION FORM

Last Name: ____________________First Name: __________________ DOB_________

SEX: Circle M F

Insurance Co: ______________________ Policy#_________________________________

Secondary Ins._____________________ Policy #_________________________________

Subscriber of Policy _________________ Subscriber D.O.B________________________

Patient relationship to Subscriber (i.e. Spouse, Child…) _____________________________

By signing this I attest that the above insurance information is correct and if the information provided is not correct, I will be responsible for any balance due for services. I also acknowledge that I have an obligation to inform Metrowest Podiatry Services, PC if the information should change at any time.

MEDICARE PATIENTS: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I understand that I am responsible for insurance deductibles and co-insurance payments on all services. When Medicare is deemed the secondary insurance, I will follow payment terms.

Signature:_______________________________ Date:______________________

MANAGED CARE REFERRAL WAIVER

As a member of a Managed Care Plan, I understand that I have an obligation to obtain a referral for a specialist from my primary care physician prior to my visit with the specialist. I understand that if referral is not obtained, I will be responsible for all services rendered. I also understand that any balance remaining after Primary & Secondary insurances have payed their portion will be my responsibility.

Signature:_______________________________ Date:______________________