Insurance Update Form

If you have new insurance information but the rest of your demographic information has not changed (name, address, phone number, etc.), please complete the form below and give it to the front desk with your new insurance card(s):

1. **Your Name: ____**

2. **Your Date of Birth: ____**

3. **Are you the primary subscriber for your insurance** (Circle one; if yes, skip to #4)**?**

   Yes **No**

   a. **Name of the primary insurance subscriber: ___________________________**

   b. **Date of birth for the primary insurance subscriber: ____________________**

   c. **Sex of the primary insurance subscriber: ____________________**

   d. **Relationship to Subscriber** (circle one): **Spouse** **Child** **Other**

4. **Primary Insurance Carrier: ____**

5. **Primary Insurance Member ID: ____**

6. **Primary Insurance Group Number: ____**

7. **Date your new insurance became active: __________________________________**

8. **Date your previous insurance expired: ____________________________________**

9. **Do you have secondary insurance** (Circle one; if no, skip to signature)**?**

   Yes **No**

   a. **Secondary Insurance Carrier: ____**

   b. **Secondary Insurance Member ID: ____________________________________**

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c. **Secondary Insurance Group Number:** ______________________________

d. **Are you the primary subscriber for your secondary insurance** (Circle one; if yes, skip)**?**

Yes **No**

i. **Name of the primary insurance subscriber:** ________________________________

ii. **Date of birth for the primary insurance subscriber:** _________________________

iii. **Sex of the primary insurance subscriber:** ________________________

iv. **Relationship to Subscriber** (circle one): **Spouse** **Child** **Other**

10. **Date your new secondary insurance became active:** __________________________________

11. **Date your previous secondary insurance expired** (if applicable)**:** _________________________

I understand that it is my responsibility to inform Physician Associates if my insurance information has changed, and failure to do so may result in the insurance carrier denying my claim, making me financially responsible in full for my visit. I attest that the information provided on this form is accurate, and that there are no other changes to my demographic information.

Signature: ____

Date: ____

For Office Only: *Please include a copy of the front and back of any new insurance cards*