Private Insurance Form for Prescription Benefits

□ I acknowledge that this information is to be used for the submission of Prescription Benefit Coverage ONLY and will not be used to bill any services, but Prescription Prior Authorizations at the Melmed Center.

Insurance company: _ _ _ _ Phone: ____________Employer:____________________

Group/Policy#_____________ Employee SS# __

Employee/Insured's name:____________________________DOB:__________________________

Insurance mailing address: _

BY SIGNING BELOW, YOU ARE STATING THAT YOU UNDERSTAND AND AGREE TO <u>ALL</u> OF THE ABOVE

__________________________________ __________________________________

Signature of Patient/Responsible Party Relationship to Patient

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