



melmed center

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# _____ ID# _____ Employee SS# _____

Employee/Insured's name: _____ DOB: _____

Insurance mailing address: _____

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

Signature of Patient/Responsible Party

Relationship to Patient