SAPERIA ORTHOPAEDICS & SPORTS MEDICINE, INC.
INSURANCE INFORMATION

PATIENT NAME:

BLUE SHIELD PRODUCTS: ☐ **Master Health Plus** ☐ **HMO Blue** ☐ **Blue Choice** ☐ **Other**

Certificate # : Blue Shield State :

Subscriber's Name Relationship to Patient

MEDICARE B: Medicare # : **MEDEX** # :

MEDICAID: Mass Health # : RID # :

Do you have managed care with MassHealth? ☐ Yes ☐ No

If *YES*, name of PCC doctor:

HMO: ☐ Harvard Pilgrim ☐ United Health Care ☐ Tufts ☐ Secure Horizons ☐ Aetna/U. S. Healthcare

Is your HMO managed care through Mass Health? ☐ Yes ☐ No

If *YES*, name of PCC: Telephone No. ( )

Policyholder Name : Policy # : Group # : Member # :

MANAGED CARE INSURANCES / PPO'S

Insurance Company Name:

Address: Street City State Zip Code

Policyholder Name : Policy # : Group # : Member # :

WORKMAN'S COMPENSATION: Name of Employer

Name of Comp. Insurance Company : File # :

Address: Street City State Zip Code

Adjuster's Name : Telephone No. : ( )

AUTO ACCIDENT: Name of Insurance Company : File # :

Address: Street City State Zip Code

Adjuster's Name : Telephone No. : ( ) : Name of Insured :

Do you have other health insurance? ☐ Yes ☐ No (If *Yes*, please complete the appropriate health insurance portion)

Do you have an attorney for this injury? ☐ Yes ☐ No

Attorney Name: Telephone No. ( )

Address: Street City State Zip Code

I hereby authorize Saperia Orthopaedics and Sports Medicine, Inc. to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made directly to Saperia Orthopaedics & Sports Medicine, Inc. I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date: **Signature:**