

Hawthorne Medical Associates – Insurance Form

(You may copy the front and back of your insurance cards instead of completing this form, if you wish).

Patient Name: _____

Patient Date of Birth: _____

Subscriber/Policy Holder Name: _____

Subscriber/Policy Holder Date of Birth: _____

Name of Insurance Company: _____

Policy Number: _____

Group Number: _____

Group Name (employer): _____

Type of Plan: (Medicare) (HMO) (POS) (PPO) (HRA/HSA)
(Other: _____)

Address to File Claims:

Insurance Co. Telephone number _____

PCP _____

Copay _____ Deductible _____

Wellness/Preventive Coverage: _____