Moonat Medical Assoc Inc.
17030 Nanes Drive. Suite 211. Houston, TX 77090
Ph: (281) 440-5925 Fax: (281) 440-3324

Insurance Verification

(Please Fill out information in box below only)**

HMO ☐ PPO ☐ POS ☐ EPO ☐ GROUP ☐ IPA ☐

Insurance Company _____ Phone No. _____

Subscriber Name _____ DOB _____

Patient's Name _____ DOB _____

Insurance ID # _____Group #_____ Effective Date _____

Pre-existing Apply: Yes _____ No _____ How Long _____

Co-Pay: OV _____ Office Surgery _____ Hospital _____

Deductible: OV _____ Met _____ Amt. Met _____ % Plan pays after ded. _____

Covered Benefits: *Annual Physicals*: Male ☐ Female ☐ WWE ☐ Pap ☐ Mammogram ☐

EKG's ☐ Immunization ☐ Flu Vaccine ☐

How Often _____ How much Covered _____

Contract Lab _____ Deductible_____ Met _____ Amt. Met _____

Pre-Cert Needed: Office Surgery _____ Hospital _____ Phone No _____

Referral Needed _____PCP's Name _____

Claims Mailing Address _____

_____

Payor ID No._____ IPA Affliation_____

Verified By _____ Spoke to_____Date _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES RENDERED.

PATIENT'S SIGNATURE _____ DATE _____

**** PLEASE PROVIDE YOUR DRIVER'S LICENSE AND CURRENT INSURANCE CARD****