Paul L. Kuflik, M.D.

Insurance Information
Dr. Paul Kuflik

Insurance Information

	Primary	Secondary
Insurance Co. Name:		
Insurance Co. Address:		
Insurance Co. Telephone:		
Policy Number:		
Group Number:		
Name of Insured:		
Insured's Date of Birth:		
Relationship of Insured:		
Effective Date:		
Expiration Date:		

PERMANENT INSURANCE SIGNATURE

I request that payment of authorized Medical Benefits be made either to me or on my behalf to the Department of Orthopaedics – Faculty Practice Associates for any service furnished to me by my physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. Photostat of this authorization shall be considered as effective and valid as the original.

I acknowledge that I am financially responsible for charges not covered by my insurance carrier due to the physician's non-participating/ out-of-network status with my insurance carrier and /or due to a lack of referral or prior authorization required for today's services should one not be present at the time of service. I acknowledge that I am financially responsible for any deductible, coinsurance, and/or co-payment deemed my responsibility by my insurance carrier as well as any non-covered charges.

Print Patient's Name

Patient's (Or Guardian's) Signature **Date**