

**MCV HOSPITALS AND PHYSICIANS
SPORTS MEDICINE REGISTRATION FORM**

The completion and verification of all requested information is critical to proper billing. Failure to provide this information may result in billing errors. THANK YOU FOR YOUR CO-OPERATION!

Name: _____ SSN: _____ Referring MD: _____

Address: _____ DOB: _____ Patient Employer: _____

_____ Employer Address: _____

Email Address: _____

Home Phone: _____ Work Phone: _____

RESPONSIBLE PARTY INFORMATION OR WORKER'S COMP INFORMATION

Are you the responsible party ? yes no

Is this worker's comp related? yes no

If no, please complete below:

If yes, complete below:

Responsible Party Name: _____

Worker's Comp Contact: _____

Relationship to Patient: _____

Phone number: _____

Address: _____

Address: _____

Home Phone: _____

Date of WC Accident: _____

WC Claim Number: _____

INSURANCE INFORMATION

Please be sure to bring your insurance card to our office so that we are able to verify coverage.

PRIMARY INSURANCE: _____ Policy # _____ Group# _____

Effective Date: _____ Subscriber Name: _____

Relationship to Subscriber: _____ Subscriber Name: _____

Subscriber SSN _____ Subscriber DOB: _____

Subscriber Employer: _____ Address: _____

Subscriber Employer Phone number: _____

SECONDARY INSURANCE: _____ Policy # _____ Group# _____

Effective Date: _____ Subscriber Name: _____

Relationship to Subscriber: _____ Subscriber Name: _____

Subscriber SSN _____ Subscriber DOB: _____

Subscriber Employer: _____ Address: _____

Subscriber Employer Phone number: _____

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Patient Name: _____

SSN: _____

When did your problem start: _____
Specify Date (Month/Year)

Who is your family physician: _____

Address: _____

Phone: _____

AUTHORIZATION/MEDICARE LIFETIME SIGNATURE AGREEMENT:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carries, or billing agents of the physician or supplier, any information needed for this or related Medicare claim. I permit a copy of this authorization to be sent in place of the original and I request payment under Medicare to be made to either me or the physician, provider, or supplier identified below for services furnished by that physician, provider or supplier.

I authorize the release of any medical information necessary to process this claim and payment of medical benefits to the MCV Physicians for services rendered.

SIGNED (Patient or Parent if Minor)

Date