

# Glenwood Medical Associates, P.C.

## CONTRACTED INSURANCE SET-UP SHEET

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

GMA Account # \_\_\_\_\_

[Please Print]

Insurance Plan Name: \_\_\_\_\_ Insurance Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Primary Insured's Name(PRINTED) : \_\_\_\_\_ Primary Insured's DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address of Primary Insured: \_\_\_\_\_

Primary Insured's Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home Phone # ( \_\_\_\_\_ ) \_\_\_\_\_

Is Insurance through employment? YES \_\_\_\_\_ NO \_\_\_\_\_ If YES, work phone Number ( \_\_\_\_\_ ) \_\_\_\_\_

Name of Employer: \_\_\_\_\_ **FULL Name(s) of those covered under the same insurance:** \_\_\_\_\_

Spouse \_\_\_\_\_ Children \_\_\_\_\_

**PLEASE MAKE COPY OF INSURANCE CARD (Front and Back) — CO-PAY MUST BE PAID ON DATE OF SERVICE**

### CONDITIONS OF SERVICE

1. The patient or responsible party must present an insurance card or policy at the time of admission in order for coverage to be considered.
2. In order to accept and bill insurances, assignment of benefits to Glenwood Medical Associates, P.C. must be made by the patient and all necessary insurance forms signed and provided by the patient.
3. When insurance assignment is accepted, payment must be received from the insurance carrier within forty-five (45) days of billing.
4. If, for any reason, Glenwood Medical Associates, P.C. receives a written or oral rejection of the claim from the insurance carrier, the patient or responsible party shall remit the balance due. This would include incorrect discounts or adjustments that are not in accordance to the contractual provisions established between GMA and insurance carrier.
5. The patient will be responsible for all non-covered services and any balance due after the insurance payment. **I further understand that if Glenwood Medical Associates files an insurance claim on my behalf and the insurance carrier incorrectly discounts or takes adjustments that are not in accordance with the contractual provisions established between Glenwood Medical Associates and insurance carrier, the balance remaining, will be my responsibility as a patient, to the extent permitted by Colorado State Law, to remit to Glenwood Medical Associates, P.C.**

**In all cases, if payment is not received by insurance carrier within forty-five (45) days of billing, the patient or responsible party will promptly remit the balance due. The patient balance after Insurance has paid must be received within sixty (60) days.**

**Patient will be responsible for filing all insurance claims if all the necessary information is not received in Glenwood Medical Associates, P.C.'s business office within ten (10) days of discharge from the hospital.**

### ASSIGNMENTS OF BENEFITS

I authorize direct payment to Glenwood Medical Associates, P.C. and all professional sub-providers of all medical benefits applicable to my treatment.

### RELEASE OF INFORMATION / INSURANCE CLAIMS

I authorize the release of any medical information necessary to process insurance claims. I hereby certify that I have read the conditions of service stated above and understand the payment policy of Glenwood Medical Associates, P.C.

**DELINQUENCY CHARGE:** The below signed agrees to pay Glenwood Medical Associates, P.C. all costs incurred by the clinic in the collection of any unpaid amount owing to the clinic including expenses, court costs, and reasonable attorney's fees.

\_\_\_\_\_  
PRINTED Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature (or Patient Representative if patient is a minor or unable to sign)