PINK
Plastic Surgery

Windy Olaya, MD

P 714-564-9225
F 855-230-1459

Insurance Form

Primary Insurance:

Patient's Name____
Member ID: ____
Group Name:____
Group number:____
Relation to primary insured: [ ] self [ ] spouse [ ] parent
Name of primary insured (if other than self) :_____________________
Date of Birth of primary insured (if other than self) :________________
Gender of primary insured (if other than self) :____________________

Secondary Insurance:

Patient's Name____
Member ID: ____
Group Name:____
Group number:____
Relation to primary insured: [ ] self [ ] spouse [ ] parent
Name of primary insured (if other than self) :_____________________
Date of Birth of primary insured (if other than self) :________________
Gender of primary insured (if other than self) :____________________

RELEASE & ASSIGNMENT OF INSURANCE BENEFITS

_______ (initial) I hereby authorize Windy A. Olaya, MD to release any and all medical information needed to process my insurance claim or for utilization review and financial audit. I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to Windy A. Olaya, MD.

_______ (initial) Bills are ONLY sent by email, please provide information.

_______ (initial) I know it is my responsibility to make sure my insurance information is up to date and correct. I understand I will be liable for all charges not covered by the insurance.

Signature: ____________________________________Date:____________

* Patient is Spanish Speaking and this form was translated by Griselda Rameriz

1310 W. Stewart Dr, Suite 511, Orange, Ca 92868