CORNERSTONE MEDICAL ASSOCIATES, LLC

Office of Titus A. Taube, MD

Verification of Benefit Form

Patient Name: _____ Date of Birth: _____

Pharmacy Name and Location: _____ SS#: _____

Preferred Language: _____ Gender: ❑ Male ❑ Female Race: _____

Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic or Latino ❑Unreported/Decline

Email Address: _____

Billing Address: _____

Street City Zip

Home Phone: ( ) _____ Cell: ( ) _____ Work: ( ) _____

Emergency Contact: _____

Name Phone Number Relationship to Patient

INSURANCE INFORMATION: *please complete*

Primary Insurance: _____

Policy Name Policy ID# Group Name/Number

Policy Holder: _____

Name of Policy Holder DOB Relationship to Patient

Secondary Insurance: _____

Policy Name Policy ID# Group Name/Number

Policy Holder: _____

Name of Policy Holder DOB Relationship to Patient

I hereby authorize the release of any medical information necessary to secure payment of benefits for services rendered and authorized the use of this signature in all insurance submissions. I hereby assign payment directly to Cornerstone Medical Associates, LLC of all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered by my contract.

I understand it is my responsibility to inform this office of any changes with my insurance, address, phone number, or any other contact information. By signing below, I verify the information above is correct and current as of the date indicated. DEMOGRAPHIC AND INSURANCE INFORMATION ABOVE IS CORRECT AS VERIFIED BY:

Name: _____ Date: _____ Name: _____ Date: _____

Name: _____ Date: _____ Name: _____ Date: _____

Name: _____ Date: _____ Name: _____ Date: _____

Name: _____ Date: _____ Name: _____ Date: _____

Name: _____ Date: _____ Name: _____ Date: _____

Name: _____ Date: _____ Name: _____ Date: _____