Allergy, Asthma, and Immunology Associates, P.C.
600 N. Cotner Blvd. Suite 208
Lincoln, NE 68505

Phone: 402-464-5969
Fax: 402-464-3657

CHANGE OF INSURANCE FORM

Today's Date: _____

Patient Name: _____ Date of Birth: _____
Names of family members that are **also patients in our office** who are affected by this insurance change:

_____ Date of Birth: _____

_____ Date of Birth: _____

_____ Date of Birth: _____

_____ Date of Birth: _____

Previous insurance company: _____ Termination Date: _____

New insurance company: _____ Effective Date: _____

****Primary Insurance Company**
Name of subscriber: _____ Subscriber ID #: _____
Name of insurance company: _____
Policy/Group number of new insurance: _____
Date of birth of subscriber: _____ SS # of subscriber: _____
Address of subscriber: _____
City: _____ State _____ Zip Code: _____
Home Telephone # (____) _____
Subscriber's employer: _____ Subscriber's Work phone: _____
Relationship to the patient: _____

****Secondary Insurance Company**: _____ Effective date: _____
Name of subscriber: _____ Subscriber ID #: _____
Name of insurance company: _____
Policy/Group number of secondary insurance: _____
Date of birth of subscriber: _____ SS # of subscriber: _____
Address of subscriber: _____
City: _____ State _____ Zip Code: _____
Home Telephone # (____) _____
Subscriber's employer: _____ Subscriber's Work phone: _____
Relationship to the patient: _____

** Please submit a front and back copy of insurance card along with this form**

FOR OFFICE USE ONLY

CHECKLIST - INFORMATION ROUTED TO:
Previous insurance filer: _____ Acct # _____
(Include patient account # on form).
Change information in computer and on chart. _____
Serum room notified: _____
Shot room notified: _____
New insurance filer: _____
Form to be filed in chart.