Peyton Manning Children's Hospital at St.Vincent

PEDIATRIC ORTHOPEDIC SURGEONS OF INDIANA

VERIFICATION OF INSURANCE BENEFITS

Patient Name: _____ D.O.B. _____

By signing my name below, I am agreeing that:

- The copy of the insurance card presented is current and has the correct insurance information.
- I am still covered under this policy.
- The co-pay listed on the card will be paid at the time of service (unless other arrangements have been made).

If I sign this form and the insurance card is later found to be expired of invalid, I understand that I am responsible for paying for the services in full and filing to the insurance carrier myself.

Signature of parent/responsible party	Date signed
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____