

SOUTHEAST VALLEY OBSTETRICS & GYNECOLOGY, PLC
6944 East Broadway Road, Mesa Arizona 85208
480-464-2101

INSURANCE INFORMATION LETTER/CONSENT FORM

1. Our office is a participating provider with most insurance plans, including a majority of AHCCCS plans.
2. **You**, as the insured, are responsible for confirming your plan is current and active. You are also responsible for knowing your coverage, deductible, coinsurance requirements and co pays.
3. **You**, must provide the office with accurate information on the insured subscriber's full name, date of birth, and social security number. You must also provide your insurance ID, group number, and claims address for each insurance policy. At the time of your service, you must provide the office with all insurance cards, primary and secondary.
4. As a courtesy, we will file your insurance claim. You are expected to pay your co pay at time of service.
5. If insurance company has not paid after 60 days, you will be responsible for the balance of your account in it's entirety.
6. **You, are** responsible for keeping the office informed of any changes to your insurance plans, phone number and billing address changes.
7. Your **primary** insurance company will set the allowable amount for your office visit.
8. We will also bill any remaining balance due to your secondary insurance plan as a courtesy. Your secondary plan may determine that the amount paid by your primary plan exceeds the amount allowed by your secondary plan. If your secondary plan does not cover the remaining balance, you will be responsible for the difference and expected to pay in full.

Signature

Date