

PLEASE NOTE: IT IS YOUR RESPONSIBILITY TO CHECK WITH YOUR INSURANCE COMPANY TO SEE IF A REFERRAL IS NEEDED FOR YOUR VISIT HERE.

I UNDERSTAND THAT IF I HAVE NOT OBTAINED A REFERRAL VOUCHER/NUMBER FROM MY PRIMARY CARE PHYSICIAN FOR OFFICE VISIT/PROCEDURE WHEN NECESSARY, I WILL BE FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED BY EYE ASSOCIATES OF UTICA, P.C.

SIGNATURE _____ DATE _____

WE PARTICIPATE WITH THE FOLLOWING INSURANCES:

- MEDICARE, EXCELLUS, MEDICARE COMPLETE, MEDICARE TODAYS OPTIONS
- BLUE CROSS/BLUE SHIELD OF UTICA/WATERTOWN
- UNITED HEALTHCARE (EMPIRE, METROPOLITAN, TRAVELERS)
- NORTH AMERICAN ADMINISTRATORS (NOW MERITAIN HEALTH)
- RMSCO
- AETNA
- TRICARE (BUT NOT HMO TRICARE)
- POMCO
- HMO BLUE
- MVP
- UNIVERA
- CDPHP
- FIDELIS
- RAILROAD MEDICARE
- TRICARE (WITH REFERRAL)

FOR INSURANCES WE DO NOT PARTICIPATE WITH, OUR OFFICE REQUIRES PAYMENT AT THE TIME OF YOUR VISIT. WE WILL PROVIDE YOU WITH AN ITEMIZED RECEIPT FOR YOU TO SUBMIT TO YOUR INSURANCE CARRIER.

WITH PARTICIPATING INSURANCE COMPANIES YOU MAY STILL BE RESPONSIBLE FOR COPAYS, DEDUCTIBLE OR NON-COVERED SERVICES.

I WILL BE FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED.

SIGNATURE _____ DATE _____
(PATIENT OR RESPONSIBLE PARTY)

WORKER'S COMPENSATION RELATED	MOTOR VEHICLE RELATED
INSURANCE COMPANY	INSURANCE COMPANY
ADDRESS	ADDRESS
CONTACT PERSON & PHONE #	CONTACT PERSON & PHONE #
CLAIM #	WCB# CARRIER CASE #/FILE #
DATE OF ACCIDENT	DATE OF ACCIDENT ARE YOU WORKING? <input type="checkbox"/> YES <input type="checkbox"/> NO
POLICYHOLDER'S NAME	EMPLOYER AT TIME OF INJURY
	EMPLOYER ADDRESS