

INSURANCE RELEASE FORM

Center for Women's Health
4840 College Boulevard
Overland Park, KS 66211-1601
(913) 491-6878 (913) 491-6808 (FAX)
www.hodesnauser.com

Herbert C. Hodes, M.D.
Traci L. Nauser, M.D.
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Name: _____ SS # _____ - _____ - _____ DOB: ____ / ____ / ____
Last First M.I.

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

Insurance Company: _____ ID# _____ Group# _____

Subscriber Name: _____ Social Security #: _____ - _____ - _____ DOB: ____ / ____ / ____

Relationship to you: _____ Subscriber Employer: _____

Subscriber Address: _____ City, State & Zip: _____

Subscriber Phone #: (____) _____

Please check my Insurance Coverage for one or more of the following:

Gen'l: ____ Maternity: ____ Surgery: ____ Contraception: ____ Tubal: ____ IUD: ____ Other: ____

Last Menstrual Period: ____ / ____ / ____ Appt Date: ____ / ____ / ____ Blood Type (if known): ____

Signature: _____ Date: ____ / ____ / ____

Signature: _____ Date: ____ / ____ / ____
(Parent or Guardian-if a Minor)

This form must be completed IN FULL in order to verify benefits for you. Verification of benefits is NOT A GUARANTEE OF PAYMENT. Please FAX this completed form along with an enlarged photocopy of the front AND back of your Insurance Card to (913) 491-6808. Information must be received a minimum of 48 hours prior to appointment time. Due to HIPAA Privacy laws, incomplete forms will NOT be processed. Please make sure ALL information is complete.