INSURANCE COVERAGE

San Diego Pediatrics accepts many insurance plans. If you are selecting or switching insurance plans and have questions, please call and speak with our billing department. **Families are always encouraged to verify coverage and benefits with their insurance company directly. We are not able to determine network restrictions set by your insurance company.**

Some insurance plans require the selection of a PCP (Primary Care Physician) or PCM (Primary Care Manager.) By selecting any one of our physicians, your child will be able to be seen by all providers at San Diego Pediatrics.

If your child has duel coverage, the primary will always be the private if the other is a Medi-cal product. If both Insurances are private, primary will go by subscriber's date of birth (first Birthday in the year).

Your copay is due at the time of service. All other patient balances, including deductibles and shares of cost, will be billed to you after your insurance company has been billed.

Please be sure to bring your insurance card to every appointment. It is your responsibility to keep San Diego Pediatrics updated and informed of any changes to your child's insurance coverage as soon as you learn of the change. This includes the addition of a secondary insurance policy.

******Please fill out this form with all information that is applicable to your coverage.******

PRIMARY INSURANCE

PATIENT'S FIRST NAME:	PATIENT'S LAST NAME:	PATIENT'S DATE OF BIRTH:

SUBSCRIBER:	RELATION TO PATIENT:	NAME OF INSURANCE CO.:
PATIENT'S INSURANCE ID NUMBER:	GROUP NUMBER:	COPAY AMOUNT:

SECONDARY INSURANCE

If your child has duel coverage, the primary will always be the private insurance if the other is a Medi-cal product. If both Insurances are private, primary will go by subscriber's date of birth (first Birthday in the year).

SUBSCRIBER:	RELATION TO PATIENT:	NAME OF INSURANCE CO.:
PATIENT'S INSURANCE ID NUMBER:	GROUP NUMBER:	COPAY AMOUNT:

Authorization to pay benefits: I hereby authorize payment directly to Joel M. Snyder M.D. AMC for any procedures including surgical, medical, physicals, and immunizations. I understand that if I am not eligible under the terms of my health plan agreement, or if for any reason the insurance company does not pay, that I am liable for all services rendered. I also understand that I am liable for fees incurred for missed appointments.

Primary insured: X____

Authorization for Medical Care: X_____________________________________