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

INSURANCE COMPANY
_____
ADDRESS
_____
CONTACT PERSON & PHONE #
_____
CLAIM #
_____
DATE OF ACCIDENT
_____
POLICYHOLDER'S NAME
_____

MOTOR VEHICLE RELATED

INSURANCE COMPANY
_____
ADDRESS
_____
CONTACT PERSON & PHONE #
_____
WCB# CARRIER CASE #/FILE #
_____
DATE OF ACCIDENT ARE YOU WORKING? □ YES □ NO
_____
EMPLOYER AT TIME OF INJURY
_____
EMPLOYER ADDRESS
_____