



Insurance Information
FAX (970)926-6355

Thank you for choosing our office for your medical care. We are pleased to be your provider and are committed to providing the best medical care possible. A copy of your **Medical Insurance Card** must be provided to CMM to ensure proper filing of your claim. You will be directly responsible for all charges until a copy of the card is furnished. Thank you!

Medical Insurance Information

Insurance Company Name: _____

Insurance Billing Address: _____

City: _____ State: _____ Zip: _____

Insurance Telephone: (_____) _____

PPO Network (if applicable): _____

PPO Address: _____

City: _____ State: _____ Zip: _____

Subscriber Information:	Account #: _____
Subscriber Name: _____	Date of Birth: ____/____/____
Subscriber SS #: _____-____-____	Group # _____
Policy #: _____	
If policy is an employer sponsored plan, please complete the following:	
Employer Name: _____	Insurance Effective date: _____

Dependents insured under this policy: Relationship: Account #:

Name: _____ DOB ____/____/____ Spouse/Child _____

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Name: _____ DOB ____/____/____ Spouse/Child _____

I authorize payment of medical benefits to Colorado Mountain Medical for services rendered. I understand that I am financially responsible to Colorado Mountain Medical for charges not covered by my insurance carrier.

_____ Date: _____

I certify to the accuracy of the patient information above and authorize the release of any medical information necessary to process this claim.

_____ Date: _____