Primary Care Associates

Insurance Change

Attn: Data Entry (fax 316-686-7338)

Old Insurance: _____
Termination date (d/m/y): _____
New Insurance: _____
Effective date (d/m/y): _____
Group #: _____
ID #: _____
Office Visit Copay amount: _$_____
Claims Billing Address: _____

_____

Policy Holder Employer: _____
Policy Holder Name: _____
Policy Holder DOB: _____/_____/_____
Policy Holder SS #: _____-_____-_____

Family Members which applies to:

(NEED NAME, FIRST AND LAST, DOB AND RELATIONSHIP TO POLICY HOLDER)

	First Name	Last Name	Date of Birth	Relationship to Policyholder
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Signature: _____ **Date:** _____