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Coordination of Benefits

Insurance companies at times may request proof of coordination of benefits; especially when there are two working members in one household. These insurance companies are looking for additional insurance coverage. This form certifies your statement regarding proof of your insurance coverage. Any false information may result a denied claims and/or patient balances.

SINGLE POLICY

Patient: _____ D/B _____

Insurance: _____ Policy ID: _____
Policy holder: _____ Self - Spouse - Other(_____)

I, _____ certify that I have insurance through _____ and I am covered under this insurance policy through my: Self - Spouse - Other(_____). I certify that I am not covered under any other insurance policy.

X _____ / / _____
Signature Required Date

DOUBLE POLICY

Patient: _____ D/B _____

(Primary)
Insurance: _____ Policy ID: _____
Policy holder: _____ Self - Spouse - Other(_____)

(Secondary)
Insurance: _____ Policy ID: _____
Policy holder: _____ Self - Spouse - Other(_____)

I, _____ certify that I have insurance through _____ as primary through (self - spouse - other: _____) & _____ as my secondary through (self-spouse-other: _____)

By signing this Insurance Certification, I am certifying that all the information above is true and correct. I understand that I will be held responsibility for any and all balances reflected from any false information given. This information is the same information provided to my healthcare insurance carrier(s).

X _____ _____
Patient / Guardian Signature Date