KidsWatch
PEDIATRICS AND URGENT CARE

Authorization to Bill Insurance

Patient Information:

- Patient Full Legal Name:
  _____
- Patient Date of Birth (MM/DD/YYYY): _____
- Patient Medical Record Number (if known):
  _____

Insurance Information:

- **Primary Insurance Company:**
  _____
- Insurance Company Address:
  _____
- Member ID/Policy Number:
  _____
- Group Number (if applicable):
  _____
- Policy Holder Name (if different from patient):
  _____
- Policy Holder Date of Birth (if different from patient):
  _____
- **Secondary Insurance Company (if applicable):**
  _____
- Insurance Company Address:
  _____
- Member ID/Policy Number:
  _____
- Group Number (if applicable):
  _____
- Policy Holder Name (if different from patient):
  _____
- Policy Holder Date of Birth (if different from patient):
  _____

Authorization:

I, the undersigned, authorize KidsWatch Pediatrics and Urgent Care to submit claims to my insurance company(ies) listed above for services rendered to me/my child (if applicable). I

understand that I am responsible for any co-pays, co-insurance, deductibles, or other amounts not covered by my insurance plan(s).

I hereby assign all medical benefits for services rendered to me/my child (if applicable) to KidsWatch Pediatrics and Urgent Care. This includes benefits from my primary, secondary, and any other applicable insurance plans.

I understand that this authorization allows my insurance company(ies) to disclose my protected health information (PHI) to KidsWatch Pediatrics and Urgent Care for the purposes of processing claims and obtaining payment for services. This may include information about my diagnosis, treatment, and other healthcare services.

I authorize KidsWatch Pediatrics and Urgent Care to appeal claim denials on my behalf and to pursue all available avenues for reimbursement.

Release of Information:

I authorize my insurance company(ies) to release information regarding my insurance coverage and benefits to KidsWatch Pediatrics and Urgent Care

Signature:

- Patient/Legal Representative Signature: _____
- Printed Name: _____
- Relationship to Patient (if not the patient): _____
- Date: _____