Change of Insurance Form

Please bring updated insurance card to next appointment or email to frontdesk@chesapeakespeechlanguage.com

Insurance Guarantor Information

Name of Insurance Subscriber: _____ DOB: _____

Home Address: _____

_____

City State Zip Code

Relationship to Patient: _____

Phone Number: _____ SSN: _____

Effective Date of New Insurance Policy: _____

Primary Insurance Information (Chesapeake Speech Language Associates will only bill to the primary insurance carrier)

Primary Insurance Company: _____

Member ID/Policy#: _____ Group #: _____

Claims Address: _____ Phone #: _____

Authorization to Bill Insurance

I am an authorized beneficiary of the above insurance plan. I confirm that all the information above is accurate, and I agree to notify Chesapeake Speech Language Associates, LLC of any changes to my insurance policy and all changes will take effect at the time the new plan information is received and all applicable referrals/authorization is obtained. I hereby authorize Chesapeake Speech Language Associates, LLC to submit claims on my behalf and to release any information acquired during my examination or treatment necessary to process my claims.

Patient Name: _____ DOB: _____

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____ Date: _____