



Northern Indiana
Neurological Institute, P.C.

521 East 86th Avenue, Suite Z, Merrillville, IN 46410 Phone (219) 769-0777 Fax (219) 755-0608

PATIENT: _____

As a service to our patients, we will file your insurance claims free of charge. To do so, we will need you to complete, sign, and return this form to us. If you have any questions, please call us at 769-0777 Monday through Friday from 8:00 a.m. to 4:00 p.m. Thank you.

INSURANCE CO. NAME: _____

ADDRESS: _____

POLICY &/OR GROUP # _____

INSURED'S NAME: _____

INSURED'S S.S. # _____

INSURED'S BIRTH DATE: _____

EMPLOYERS NAME: _____

ADDRESS: _____

I hereby authorize payment of insurance benefits to Northern Indiana Neurological Institute, P.C. for services rendered to me. I understand that I am financially responsible to the physician for fees not covered by my insurance company. This authorization will remain in effect until revoked in writing.

Insured's signature _____

I hereby authorize the release of medical information to the insurance company. This authorization will remain in effect until revoked in writing.

Patient's signature _____ Date _____

WE MUST HAVE SIGNATURES TO FILE INSURANCE ON YOUR BEHALF