THE ARC MADISON CORTLAND
ARTICLE 16 CLINIC INSURANCE INFORMATION FORM

Please complete form for all insurances and copies of all insurance cards.

The Arc of Madison Cortland currently accepts all insurance plans. We are a participating provider with the following plans:

Medicaid Medicare Fidelis Excellus Blue Cross/Blue Shield

Individual's Name: _____ Date of Birth: _____

Insurance Company: _____ Policy ID #_____

Insurance Address: _____ Insurance Telephone #_____

_____

Policyholder's Name:_____

SSN: _____ DOB: _____ Marital Status: ☐ Yes ☐ No

Policyholder's Address: _____ Phone #:_____

_____

Policyholder's Employer's Name: _____

Employer Address: _____

Is the Policyholder retired? ☐ Yes ☐ No

I hereby authorize The Arc of Madison Cortland to bill my insurance company for all services provided by the Article 16 Clinic for the individual listed above. I agree to forward copies of all Explanation of Benefits (EOB's) and any payments I may receive from the above insurance company in a timely manner. If your insurance does not cover the service provided by the Arc of Madison Cortland's Article 16 Clinic, you will be responsible for the applicable fees. Service fees are discussed individually based on the individual's needs.

Policyholder's Signature: _____Date: _____