Vinu Ganti, M.D., P.C.

12800 Middlebrook Rd, Suite #204
Germantown, MD 20874

Insurance Information

PRIMARY INSURANCE INFORMATION

SUBSCRIBER'S LAST NAME		FIRST NAME	DATE OF BIRTH
SOCIAL SECURITY #	HOME PHONE	RELATIONSHIP TO PATIENT	
NAME OF PRIMARY INSURANCE COMPANY		INSURANCE ADDRESS	
CITY	STATE	ZIP CODE	
ID# OR POLICY #	GROUP # OR CODE	EFFECTIVE DATE	

SECONDARY INSURANCE INFORMATION

SUBSCRIBER'S LAST NAME		FIRST NAME	DATE OF BIRTH
SOCIAL SECURITY #	HOME PHONE	RELATIONSHIP TO PATIENT	
NAME OF PRIMARY INSURANCE COMPANY		INSURANCE ADDRESS	
CITY	STATE	ZIP CODE	
ID# OR POLICY #	GROUP # OR CODE	EFFECTIVE DATE	

PATIENT AUTHORIZATION

I, _____________________________________, hereby authorize Vinu Ganti, M.D., to apply for benefits on my behalf for coverage services rendered. I request payment from BC/BS, National capital area, Blue Shield of Maryland, Medicare, and / or ____ insurance company, be made directly to the above named provider (or in case if Medicare Part B benefits, to my self or the party who accepts assignment). I certify that the information I have reported regarding to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above name billing agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration and / or the insurance company named above). I permit a copy of this authorization to be used in place of the original. Either the above named carrier or I may revoke this authorization at any time in writing. I request the payment of authorized Medigap benefits be made either to me or on my behalf to the above named provider for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to be released to ______________________________________and any information needed to determine the benefits payable for related service (Name of Medigap Carrier)

I agree that any balance not covered by the insurance company is my responsibility to pay. If balances are not paid in a timely manner, Vinu Ganti M.D. P.C. will proceed with their office policies and procedures to collect the outstanding balance which may include turning my account to an outside collection agency.

____ ____

DATE **SIGNATURE OF SUBSCRIBER OR BENEFICIARY**