Yorktown Health
Women's Personalized Care

SECONDARY INSURANCE UPDATE

PATIENT NAME _____

SECONDARY INSURANCE _____

SECONDARY POLICY HOLDER _____

SECONDARY POLICY HOLDER'S DATE OF BIRTH _____/_____/_____

SECONDARY POLICY HOLDER'S SS# _____-____-_____

SECONDARY POLICY HOLDER'S EMPLOYER_____

EMPLOYER'S ADDRESS _____

EMPLOYER'S PHONE NUMBER (_____)_____-_____

***I AUTHORIZE PAYMENT OF MEDICAL BENEFITS FROM ALL INSURANCE CLAIMS TO BE MADE DIRECTLY TO Yorktown Health/ANDREW A. ROTH M.D., S.C.

SIGNATURE_____ DATE_____/_____/_____