INSURANCE INFORMATION

Payment will depend on insurance coverage. The insurance information requested below must be received in this office no later than **five** working days prior to your scheduled appointment so that we may verify your coverage. No copayment will be accepted if insurance cannot be verified and **payment in full is due at the time service is rendered.** If you do not have insurance coverage, or you have coverage but it does not cover infertility, **payment in full is due at the time service is rendered.**

Mail to: Alfred J. Rodriguez, M.D.
6130 West Parker Rd. Ste 215
Plano, Texas 75093
Attention: Rona Wilkins
Or you may fax the info to: (972) 981-7814

PATIENT
NAME:_____

ADDRESS:_____

SOCIAL SECURITY NUMBER:_____

DATE OF BIRTH: _____

DAYTIME PHONE NUMBER: _____

NAME OF INSURANCE: _____

INSURANCE PHONE NUMBER:_____

MAILING ADDRESS OF CLAIMS: _____

INSURED MEMBER'S NAME: _____ RELATION: _____

INSURED'S SSN OR SUBSCRIBER ID: _____

GROUP OR ACCOUNT NUMBER: _____

INSURED'S EMPLOYER: _____ DATE OF BIRTH: _____

CHIEF COMPLAINT OR DIAGNOSIS:
_____

*****PLEASE ATTACH A COPY OF BENEFITS FROM YOUR BENEFIT BOOKLET OUTLINING YOUR INFERTILITY BENEFITS WE CALL YOUR INSURANCE COMPANY AS A COURTESY TO YOU, BUT VERBAL INFORMATION IS NOT ALWAYS RELIABLE****