VASCULAR SURGERY

KOSIT PRIEB, M.D., F.A.C.S.
ROBERT D. H. LEE, M.D., F.A.C.S.

311 West Lincoln, Suite 200
Belleville, Illinois 62220
618/233-2500 • 1-800-427-3347

VASCULAR & HAND SURGERY LTD.
VHS

HAND SURGERY

KOSIT PRIEB, M.D., F.A.C.S.

6812 State Route 162, Suite 202
Maryville, Illinios 62062
618/233-2500 • 1-800-427-3347

DATE: _____

PATIENTS NAME: _____

ACCOUNT NUMBER: _____

- WE WILL BE SUBMITTING YOUR CHARGES FOR DR. KOSIT PRIEB AND/OR DR. ROBERT LEE'S SERVICES TO YOUR INSURANCE COMPANY/COMPANIES. PLEASE COMPLETE AND SIGN THE BOTTOM PORTION OF THIS LETTER.

- WE **DO** ACCEPT ASSIGNMENT OF MEDICARE CLAIMS.

PRIMARY INSURANCE CARRIER:_____
INSURANCE ADDRESS_____
_____
POLICY AND/OR GROUP NUMBER(S)_____
SUBSCRIBER'S NAME_____
SUBSCRIBER'S SOCIAL SECURITY NUMBER_____
EFFECTIVE DATE (IF ON INSURANCE CARD)_____
INSURED'S DATE OF BIRTH_____

SECONDARY INSURANCE CARRIER:_____
INSURANCE ADDRESS_____
_____
POLICY AND/OR GROUP NUMBER(S)_____
SUBSCRIBER'S NAME_____
SUBSCRIBER'S SOCIAL SECURITY NUMBER_____
EFFECTIVE DATE (IF ON INSURANCE CARD)_____
INSURED'S DATE OF BIRTH_____

* USE REVERSE FOR ANY ADDITIONAL PLAN(S) THAT WILL COVER THIS BILL.

* I AUTHORIZE RELEASE OF INFORMATION TO MY INSURANCE COMPANY/COMPANIES. I UNDERSTAND I AM RESPONSIBLE FOR BY BILL. I AUTHORIZE PAYMENT DIRECTLY TO MY PHYSICIAN. I AUTHORIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS. I AUTHORIZE THIS PRACTICE TO ACT AS MY AGENT TO HELP ME SECURE PAYMENT FROM MY INSURANCE COMPANY/COMPANIES.

* IN THE EVENT THAT THIS ACCOUNT IS REFERRED TO AN ATTORNEY WHO IS IN YOUR EMPLOYMENT FOR COLLECTIONS, I WILL BE RESPONSIBLE FOR ALL COLLECTION COSTS INCLUDING REASONABLE ATTORNEY FEES.

**** DOES YOUR INSURANCE REQUIRE PRE-CERTIFICATION? YES NO**

**** ARE WE SEEING YOU FOR A LIABILITY OR WORK RELATED INJURY OR CONDITION? YES NO**

_____ _____
DATE SIGNATURE OF PATIENT OR RESPONSIBLE PARTY