



**PREFERRED PEDIATRICS**  
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## INSURANCE CHANGE FORM

Today's Date: \_\_\_\_\_

Old Insurance: \_\_\_\_\_

New Insurance:

Subscriber Name (or name on card)	Effective Date
Subscriber Date of Birth	
Member ID:	Group ID:
Claims Address	Name of Patient(s)  Date of Birth:

 <b>ABC INSURANCE</b> PARTNERS	
<b>1</b> Member Name <b>JOHN Q SAMPLE</b>	OFFICE VISIT \$30
<b>2</b> Member ID Number <b>HFM3HZN12345678</b>	URGENT CARE \$50
<b>3</b> GROUP NUMBER 012345-6789	SPECIALIST \$30
<b>4</b> EFFECTIVE DATE XX/XX/XXXX	EMERGENCY ROOM \$100
<b>5</b> PLAN CODE 380/780	RxBIN 012345
CONTRACT TYPE FAMILY	RxPCN ABCD
PCP NAME <b>DOE DR, JOHN</b>	RxGRP 0123456789
	<b>PPO</b>

www.ABCInsurance.com	
24/7 Nurse Health Information Line call 1-888-123-4567	
For EAP and Behavioral Health assistance 1-888-123-4567	
24/7 Doctors at 1-888-123-4567 or Teladoc.com	
The primary care cvmdv czvlm clzdf lvdm,vv,xz.v,mvc afkc ,d ,vd vdl amv m,xzcv czlv ,ZLv fv,v,v,z/XV,z v ,cvclvb vFoff mv cv,mv z vd mcmxzvZLVm vmvdmF dfefke md" vzVI mv vdmvlvbmvlmbls acfdvdfi.	
<b>6</b> ABC Insurance Partners P.O. BOX 12345 ANYWHERE US 123456 - 0789	
<b>7</b> MEMBER SERVICES	1-888-123-4567
PRECERTIFICATION ONLY	1-888-123-4567
RX MEMBER SERVICES	1-888-123-4567

- 1 SUBSCRIBER NAME:** If commercial insurance this is the name of parent carrying insurance. All other insurance it is patient name.
- 2 MEMBER ID:** If card does not say Member ID this usually the top set of numbers.
- 3 GROUP ID:** Card will say Group ID or use second set of numbers.

- 4 EFFECTIVE DATE:** Date Insurance coverage started.
- 5 PRIMARY CARE:** This should be the name of a provider in our office.
- 6 CLAIMS ADDRESS:** This is the address of your insurance company.
- 7 MEMBER SERVICES:** This number is for customer service.