

Plaza Medical Centre

700 N Pearl St, Suite N208
 Dallas, TX 75201
 Tel: (214) 999-9355

**Griego Family Medical Centre**

2701 S Hampton Rd, Suite 101
 Dallas, TX 75224
 Tel: (214) 330-9221

ASSIGNMENT OF INSURANCE BENEFITS/ELIGIBILITY CERTIFICATION

Primary Insurance Plan		
Patient Name	Date of Birth	
Insurance Plan	Group #	Policy #
Insurance Company Address		Phone #
Subscriber Name	Relationship to Patient	
Subscriber Certificate/Social Security #	Subscriber Date of Birth	
Subscriber Employer	Employer Phone #	
Employer Address		
For Medicare Patients Only		
Health Insurance Claim #	Part A Effective Date	Part B Effective Date
Other Insurance Coverage for Patient		
Patient Name	Date of Birth	
Insurance Plan	Group #	Policy #
Insurance Company Address		Phone #
Subscriber Name	Relationship to Patient	
Subscriber Certificate/Social Security #	Subscriber Date of Birth	
Subscriber Employer	Employer Phone #	
Employer Address		
<input type="checkbox"/> I hereby authorize and request that payment of authorized Medicare/other insurance company benefits be made on my behalf, be paid directly to Griego Family Medical Centre for any medical or surgical services rendered by its affiliated medical groups to me or a member of my family. I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its agents or carriers, or the insurance company any information needed for this or a related Medicare/other insurance claim to determine these benefits or the benefits payable for related services. I understand that it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment.	<input type="checkbox"/> I understand that I am eligible for benefits through my HMO policy. I understand that my assigned IPA/Medical Group chosen for my benefits is a Griego Family Medical Centre affiliated medical group listed above. I am aware that if the above is not true, I (or the person financially responsible for me) am responsible for all charges related to services provided to me. I agree that if the above is not true, I (or the person financially responsible for me), will pay in full all such charges.	
_____ Signature of Patient /Responsible Party		_____ Date
_____ Name of Patient/Responsible Party (please print)		_____ Relationship to Patient