

**NEPHROLOGY ASSOCIATES OF SYRACUSE, P.C.**

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**INSURANCE INFORMATION:**

**PLEASE READ AND FILL OUT THE FOLLOWING INFORMATION. WE NEED THE MOST ACCURATE INSURANCE INFORMATION YOU HAVE IN ORDER TO EXPEDITE OUR BILLING PROCESS. PLEASE BE PREPARED TO PRESENT YOUR INSURANCE CARDS AT EVERY VISIT. THANK YOU.**

**PRIMARY INSURANCE CARRIER:**

Insurance Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Name on Card: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

**(If spouse's policy)**

Name of Spouse: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Effective Date on Card: \_\_\_\_\_

Employer: \_\_\_\_\_

**SECONDARY INSURANCE CARRIER:**

Insurance Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Name on Card: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

**(If spouse's policy)**

Name of Spouse: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Effective Date on Card: \_\_\_\_\_

Employer: \_\_\_\_\_

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