SUNIL K KOTTUR MD

Board Certified - Psychiatry & Child/Adolescent Psychiatry

2301 Ohio Dr, Suite 295, Plano, TX 75093

1) Please Circle/Checkmark your insurance company:

   ___ Blue Cross Blue Shield ___Aetna ___Cigna ____American Behavioral

   Member ID# _____

   Group # _____

   Customer Service Tel # (Mental Health/Behavioral)_____

   Is the Insurance policy under your name? ____Yes ____No

   If No, who is the policy under (the Primary Policy Holder)?_____

   Date of Birth of the Primary Policy Holder: _____

   Your relationship to the Primary _____

   Financial Responsibility Party: __Self __Father __Mother Other_____

2) I authorize the release of any medical or other information necessary to process this claim by my health insurance company. I also request payment of government benefits to self or Sunil Kottur, MD, if applicable.
3) I authorize my Health Insurance Company to pay for services rendered by Sunil Kottur, MD.
4) I understand that any Copay, Coinsurance or Deductible, if applicable, will be my responsibility.
5) If you have a fund like HRA/HSA/FSA, the applicable patient responsibility (Copay, Coinsurance or Deductible) will **still** be charged at the time of the visit as we do not have access to information about how much funds are available in your HRA/HSA/FSA.
6) After the claims are processed by your insurance company, your responsibility might change depending on the benefits paid and adjustments will be done accordingly.
7) We **do not** do secondary insurance billing.

_____ _____

Signature Name and Date

If patient is a minor/has guardianship, sign, name, date below and indicate relationship:

_____ _____