



160 Pehle Avenue, Suite 302  
Saddle Brook, NJ 07663

TEL: (201) 252-8700  
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## WYCKOFF PEDIATRICS Medical Insurance Information

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Insurance Name: \_\_\_\_\_ ID # \_\_\_\_\_

Address for Claim Submission: \_\_\_\_\_  
\_\_\_\_\_

Group #: \_\_\_\_\_ CoPay: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber DOB \_\_\_\_\_

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

I hereby authorize Wyckoff Pediatrics to release any medical or incidental information that may be necessary for medical care and in processing application for financial benefits.

I hereby authorize direct payment of medical benefits to Wyckoff Pediatrics for services rendered by its doctors or persons under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

A photocopy of these assignments shall be as valid as the originals.

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_