



Name: _____ Date of birth: _____

Consent to Verify Insurance Benefits and Bill Insurance

I hereby give my permission to ACRM and CCRM Atlanta (or a third party company who it designates) to obtain from my past, present or future health insurance and prescription benefits companies full and complete health insurance and medication coverage information, including, but not limited to coverage related to infertility (if applicable).

I also hereby give my permission to ACRM and CCRM Atlanta to forward certain medical information it deems necessary to an outside third party who it designates to determine my eligibility to participate in certain patient financial service programs that are made available through ACRM or CCRM Atlanta. Patients are in no way required to participate in these programs. I likewise give my permission to the third party company to forward to ACRM and CCRM Atlanta my prequalification status.

The health insurance and medication benefits verification and the financial services prequalification are offered as a courtesy and without charge. I agree to hold harmless ACRM, CCRM Atlanta, or the third party company performing the verification of insurance benefits and these companies shall have no liability should the information obtained from my insurance company and communicated to me is different from the coverage applied by my insurance company to any claims subsequently filed. I also agree to hold harmless ACRM and CCRM Atlanta and neither shall have any liability if the prequalification for a patient financial program is preliminarily granted but subsequently not granted.

Patients are encouraged to confirm all insurance or reimbursement coverage determinations directly with their insurance carrier or other reimbursement source.

HEALTH INSURANCE CARD:

Insurance Company: _____
ID number: _____ Group number/name: _____
Insured's Employer: _____ Policy number: _____
Phone number for benefits determination: _____

Signature: _____ Date: _____

Date of Birth: _____ Social Security #: _____

Your partner's / spouse's name: _____

HEALTH INSURANCE CARD:

Insurance Company: _____
ID number: _____ Group number/name: _____
Insured's Employer: _____ Policy number: _____
Phone number for benefits determination: _____

Signature: _____ Date: _____

Date of Birth: _____ Social Security #: _____

Attention All Aetna Patients - You may be required to register with Aetna's Infertility Hotline. If a patient is required by Aetna to register with the Aetna Infertility Hotline but fails to do so, Aetna will not consider paying for any services, and all services rendered will be your responsibility. Call 1.800.575.5999 to obtain your registration number, and complete the below:

My Aetna Registration No. is: _____ OR _____ I called Aetna and was informed that I am not required to register.