

# Columbia Basin Hearing Center

## Confidential Patient Insurance Information

Columbia Basin Hearing Center (CBHC) bills most insurance companies based on a contractual obligation between our hearing care providers and your insurance company. This benefits our patients so they do not have to bill their insurance themselves. **We are no longer accepting DSHS-Medicaid insurance whether it is primary or secondary. You will be billed for the balance owed after your primary insurance pays if you have Medicaid as secondary. We are sorry for any inconvenience this may cause.**

**We do recommend that you contact your insurance company regarding hearing benefits. Our billing specialist can assist you if you have any specific questions about what to ask your insurance company.**

Your insurance company may pay all or part of the audiology testing and/or products provided. All claims that have not been paid by the insurance company in 90 days and any deductibles, co-pays or balances left after your insurance pays are the **responsibility of the patient.**

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

**Primary Insurance Company** \_\_\_\_\_ **ID#** \_\_\_\_\_

Subscriber's Name / Relationship to patient \_\_\_\_\_ Subscriber's SS# \_\_\_\_\_

Subscriber's Birth Date \_\_\_\_\_ Subscriber's Address \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ Full time / Part time (please circle one)

**Secondary Insurance Company** \_\_\_\_\_ **ID#** \_\_\_\_\_

Subscriber's Name/Relationship to Patient \_\_\_\_\_ Subscriber's SS# \_\_\_\_\_

Subscriber's Birth Date \_\_\_\_\_ Subscriber's Address \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ Full time/ Part time (please circle one)

***I have read and understand the terms of the above payment policy. I authorize the release of information in my file for the purpose of processing the insurance claim***

**Patient's Signature** \_\_\_\_\_  
(Parent or Guardian if under 18)

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