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**POLICY HEALTH INSURANCE INFORMATION**

<input type="checkbox"/> BCBS of Central NY	<input type="checkbox"/> Medicare
<input type="checkbox"/> BCBS (Outside NY)	<input type="checkbox"/> Medicaid
<input type="checkbox"/> Aetna Managed Care	<input type="checkbox"/> HealthNOW
<input type="checkbox"/> Aetna PPO	<input type="checkbox"/> PHP or AHP
<input type="checkbox"/> Aetna Traditional 80/20	<input type="checkbox"/> Empire (NYS Employees)
<input type="checkbox"/> Unicare	<input type="checkbox"/> North American Administrators
<input type="checkbox"/> United Healthcare	<input type="checkbox"/> Other _____

**PRIMARY INSURANCE COVERAGE**

Insured Person (subscriber) \_\_\_\_\_  
 Policy Holder Date of Birth \_\_\_\_\_  
 ID# \_\_\_\_\_ Group# \_\_\_\_\_  
 Relationship to subscriber: \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child

**SECONDARY INSURANCE COVERAGE**

Insured Person (subscriber) \_\_\_\_\_  
 ID# \_\_\_\_\_ Group# \_\_\_\_\_  
 Relationship to subscriber: \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child

\*\*Your co-payments are due at the time of your visits. This also includes any deductible for which you are responsible.

Do you feel this condition is work related? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Is your condition related to an auto accident? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 My insurance requires authorization for physical therapy services to be initiated. \_\_\_\_\_ Yes \_\_\_\_\_ No

Cayuga Orthopaedic and Sports Physical Therapy, P.C. is a participating provider for most BCBS plans, AETNA, Empire, North American Administrators, Medicare and Medicaid. We will provide an itemized bill for patients who have any other insurance. If you have an insurance form and sign it for the payment to come directly to Cayuga Orthopaedic and Sports Physical Therapy, P.C., we will submit it to your insurance company for you.

I hereby authorize my insurance benefits to be paid directly to Cayuga Orthopaedic and Sports Physical Therapy, P.C. and I acknowledge I am financially responsible for any unpaid balance including supplies and/or durable medical equipment that is not covered by my insurance.

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Signature \_\_\_\_\_ Date \_\_\_\_\_