Avera Medical Group Internal Medicine Sioux Falls
Plaza 2
1301 South Cliff Avenue, Suite 400
Sioux Falls SD 57105
(605) 322-5750

Primary

Effective Date: _____
Subscriber: _____

Secondary

Effective Date: _____

Worker's Compensation or Accident Information

Name of Insurance or Employer:_____ Date of Injury: _____
Address: _____
Contact Person:_____
Phone #:_____ Fax #:_____
Submit Claims To: _____
(Insurance Company or Employer)_____

I request payment of authorized benefits be made on my behalf to Avera Medical Group Internal Medicine for any services furnished me by Avera Medical Group Internal Medicine. I authorize my holder of medical information to release to insurance carriers any information needed to determine benefits payable for services provided. I understand that I am responsible for any information not covered by insurance. I authorize Avera Medical Group Internal Medicine to release necessary information and medical records only as required to assure continuity of care with other health care providers, for reimbursement or for accreditation purposes.

Patient/Guardian/POA Signature:_____ Date:_____

Insurance Information