Siperstein Dermatology Group

Physicians and health care providers may be required to pre-certify services with your insurance company. The following form will need to be filled out with your signature and this signed form along with a copy of your insurance card will be faxed to **Pinnacle Health Group** at **(877) 499-2986** in order to obtain precertification for your procedure.

TO BE COMPLETED PRIOR TO PRECERTIFICATION

PATIENT INFORMATION

Name_____
Address_____City_____State____Zip Code_____
Date of birth_____ Social Security Number_____

INSURANCE INFORMATION

- See attached copy of patient demographics-

PROCEDURE

Diagnosis _____
Procedure description _____
Date of procedure _____
Body site(s) to be Treated _____

PHYSICIAN INFORMATION

Name:____Dr. Robyn Siperstein_____Tax ID Number:____271114689_____
Address:___9897 Hagen Ranch Rd._____City: ____Boynton Beach___ State: _FL_Zip Code: ___33472_____
Phone Number:_____561-364-7774_____Fax:_____561-364-7775_____
Office Contact Name: _____SUMMER_____
NPI Number: _____1609101278_____

PATIENT CONSENT

I, _____, authorize my provider and health insurance plan, to disclose to the Pinnacle Health Group and/or their representatives, information about my medical condition, treatment, and insurance coverage. For example, my diagnosis, medical history, and insurance coverage limitations as needed to authorize benefits for my procedure and determine if this procedure may be covered under the terms of my health insurance policy. Further, I consent to being contacted by the Pinnacle Health Group with respect to supporting the coverage for this procedure. I understand that I may refuse to sign this authorization and can revoke this authorization at any time, except to the extent that the Pinnacle Health Group has taken action in reliance on it, by mailing a written request to revoke this authorization to my insurance provider. I have read and understand this consent document:

*_____ *_____
Patient signature Date