Insurance Form

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Neena Gabrielle, O.D., FCOVD

Please note that Dr. Gabrielle is a non-contract provider with all insurance companies.
We do not bill your insurance. Payment is due in full at time of service.

Insurance Information:
(We are collecting this information to keep on file in case your insurance company contacts us in regards to a claim you have submitted and so that we may effectively help you get reimbursement)
"Subscriber" is the person who receives insurance coverage from his/her employer.
"Patient" may be the subscriber or may be a family member of the subscriber also covered by the insurance.

- ❑ I hereby **decline** to share insurance information as I do not plan on submitting the claims and thus do not need help with obaining reimbursement.
- ❑ I hereby **authorize the release** of any medical or other information necessary to process insurance claims in order to get reimbursements. I understand that it is my responsiblity to contact my insurance company to review benefits and eligibility. I understand that it is my responsibility to obtain any referrals or preauthorizations from my primary care physician or insurance as outlined by my insurance policy.

Patient (LAST, First)

Person Filling Out Form

Primary Insurance Company | Primary Insurance Company Phone #

Subscriber's Name | Subscriber's Birthdate (M/D/Yr)

ID Number

Group Number | Plan Name

Subscriber's Address (if different than patient's)

Subscriber's Phone # (if different than patient's)

Subscriber's Employer | Occupation

Subscriber's Work #

Signature of Patient or Responsible Party	Print Name of Patient or Responsibe Party / Relationship	Date (M/D/Yr)	Staff Initials	Date (M/D/Yr)