Name (Last, First MI) Generation (Sr., Jr., I, II, etc)

Patient ID# (Assigned by OCHD)

DOB

Onslow County Health Department (OCHD)

Assignment of Medical Health Insurance Benefits

ASSIGNMENT OF INSURANCE BENEFITS: I, the patient named above or the patient's authorized representative, understand that I may be financially responsible to OCHD for charges not covered by my medical insurance carrier(s). I authorize payment of medical benefits to OCHD on my behalf for services provided, unless other arrangements have been made. I further authorize the release of all medical information necessary to determine the extent of third party coverage. I agree to re-pay OCHD any money I receive from my medical insurance carrier for services provided to me for which I have not paid to Onslow County Health Department. I authorize the use of this signature on all insurance submissions whether manual or electronic. This assignment of benefits will remain in effect until insurance information changes or revoked in writing.

NOTE: It is the practice of medical health insurance companies, with the exception of Medicaid, to mail an explanation of benefits to the policy holder via the mail.

Attach a copy of the front/back of all applicable current insurance card(s) (i.e., Medicare, Medicaid, private insurance, and/or military ID card)

PRIMARY OR SOLE MEDICAL HEALTH INSURANCE CARRIER

☐ BC/BS	☐ ChampVA	☐ Medicaid	☐ N.C. Health Choice	☐ Tricare (Standard)
☐ BC/BS Federal	☐ Mailhandlers	☐ Medicare Part B	☐ State of N.C.	☐ Tricare (Prime)
☐ Other, provide insurance carrier's name:				
Subscriber's ID# / Policy # / Military Sponsor's SSN			Group #, if applicable	Insurance Telephone #
Is the primary policyholder the patient?		☐ Yes	☐ No, provide policyholder's information below:	
Primary Policyholder's Name			Policyholder's Birth Date	Relationship to Patient

SECONDARY MEDICAL HEALTH INSURANCE CARRIER

☐ BC/BS	☐ ChampVA	☐ Medicaid	☐ N.C. Health Choice	☐ Tricare (Standard)
☐ BC/BS Federal	☐ Mailhandlers	☐ Medicare Part B	☐ State of N.C.	☐ Tricare (Prime)
☐ Other, provide insurance carrier's name:				
Subscriber's ID# / Policy # / Military Sponsor's SSN			Group #, if applicable	Insurance Telephone #
Is the primary policyholder the patient?		☐ Yes	☐ No, provide policyholder's information below:	
Primary Policyholder's Name			Policyholder's Birth Date	Relationship to Patient

TERTIARY MEDICAL HEALTH INSURANCE CARRIER

☐ BC/BS	☐ ChampVA	☐ Medicaid	☐ N.C. Health Choice	☐ Tricare (Standard)
☐ BC/BS Federal	☐ Mailhandlers	☐ Medicare Part B	☐ State of N.C.	☐ Tricare (Prime)
☐ Other, provide insurance carrier's name:				
Subscriber's ID# / Policy # / Military Sponsor's SSN			Group #, if applicable	Insurance Telephone #
Is the primary policyholder the patient?		☐ Yes	☐ No, provide policyholder's information below:	
Primary Policyholder's Name			Policyholder's Birth Date	Relationship to Patient

Printed Name of Patient OR Authorized Representative

Signature Name of Patient OR Authorized Representative

Date