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Arlington, Texas 76014  
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1670 East Broad Street  
Suite 107  
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Phone: (817) 453-1758  
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Dear Patient:

Although we understand your insurance coverage has maternity benefits, you may be responsible for a portion of your bill. Therefore, in order to get the best estimate, we require that you contact your insurance company and get the answers to the following questions. **THIS FORM MUST BE RETURNED TO US ON YOUR NEXT OFFICE VISIT.** Failure to have this form completed may result in the rescheduling of your appointment and/or a deposit from you until this information is obtained.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Plan ID#: \_\_\_\_\_ Group # \_\_\_\_\_

Claims Address: \_\_\_\_\_

Insured Person Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Spoke to: \_\_\_\_\_ at phone #: \_\_\_\_\_

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**At the time of delivery one of the two global codes will be billed, 59400 or 59510. Our fee is \$2500 regardless of whether it is a vaginal or cesarean section birth. "Non-Global" services will be billed at the time of service.**

Policy effective date: \_\_\_\_\_

My maternity benefits have a \$ \_\_\_\_\_ deductible with a \_\_\_\_\_ %, which \$ \_\_\_\_\_ of my deductible has been met. Or a one-time co-pay of \$ \_\_\_\_\_ .

All non-global services (sonograms, labs, injections, tests, and etc.) are covered at:

\$ \_\_\_\_\_ deductible and \_\_\_\_\_ %, or a co-pay of \$ \_\_\_\_\_ each.

Although we will use this as a guideline, please know that the patient is responsible for notifying us of any changes in insurance or benefits. If you have questions about this form, please contact your OB coordinator, Lisa at extension 136.