

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: 1401 N. Federal Hwy. City: Boca Raton State: FL Zip Code: 33432 Phone
Number: 561-3955-8885 Fax: 561-955-8512
Office Contact Name: _____
GINA 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