John T. Martsolf
Pediatrics/Medical Genetics
UND School of Medicine, Room 5910
501 N. Columbia Rd, STOP 9037
Grand Forks, ND 58202-9037
(701) 777-4277
(701) 777-3220 (fax)

~~*Please fill in lines 1-16*~~

1. RESPONSIBLE PARTY NAME:_____
(Last) (First) (M.I.)
2. RELATIONSHIP TO PATIENT: Father____ Mother ____ Spouse ____ Self ____
3. ADDRESS:_____
(street/box/RR) (City) (State) (Zip) (County)
4. HOME PHONE:_____ SS#:_____ BIRTH DATE:_____
5. PATIENT NAME:_____
(Last) (First) (M.I.)
6. BIRTH DATE:_____ SEX:_____ SS#:_____
7. PRIMARY INS:_____
8. ADDRESS:_____
9. INSURED=S NAME:_____ SS#:_____
10. POLICY #:_____ GROUP #:_____
11. SECONDARY INS:_____
12. ADDRESS:_____
13. INSURED=S NAME:_____ SS#:_____
14. POLICY #:_____ GROUP #:_____

I authorize payment of medical benefits to John T. Martsolf, MD or Medical School Practice Support. I understand that I am financially responsible for deductibles, co-insurance, and non-covered services, as per insurance policy. It is agreed that if this document is a copy of the original, it will be accepted the same as the original.

15. PATIENT=S OR AUTHORIZED
PERSON=S SIGNATURE:_____ DATE:_____

I authorize the release of any medical or other information necessary to process this claim.

16. PATIENT=S OR AUTHORIZED
PERSON=S SIGNATURE:_____ DATE:_____

Billing Information (office use only)

Date of Service:_____ Place of Service:_____ Charge:_____
Referral Source:_____UPIN:_____
Procedure/Service:_____ Procedure Code:_____
Sliding Fee Schedule: Family Size: _____ Income: _____
Diagnosis: (1)_____ ICD Code_____
(2)_____ ICD Code_____
(3)_____ ICD Code_____