INSURANCE AUTHORIZATION

Primary Insurance

Insurance Company Name: _____

Subscriber ID: _____Group #: _____

Subscriber Name: _____ Subscriber Date of Birth:_____

Subscriber Mailing Address: _____

Subscriber SSN: _____Employer: _____

Secondary Insurance

Insurance Company Name: _____

Subscriber ID: _____Group #: _____

Subscriber Name: _____ Subscriber Date of Birth:_____

Subscriber Mailing Address: _____

Subscriber SSN: _____Employer: _____

Guarantor

Name: _____ SSN: _____

Relationship to Client: _____Date of Birth: _____

Mailing Address: _____

Home Phone:_____ Mobile: _____

Employer: _____ Work Phone: _____

I authorize CCC to send claim(s) to my insurance company and/or companies on my behalf and will abide by CCC Payment Policy.

Responsible Party's Signature: _____ Date: _____