

Lindenhurst Pediatrics

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Medicaid Coordination of Benefits

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

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Every year, your insurance company needs verification of whether or not you have other insurance that would be considered a primary payer. Please indicate below whether or not your child has other active coverage.

- My child has Medicaid only and has never been added to a private insurance.
- My child was on a private insurance previously, but now has only Medicaid.
Insurance Name: _____

Subscriber Number/Member ID: _____

Group Number: _____

Policy Holder's Name: _____

- My child does have an insurance that is primary and Medicaid is secondary. I am aware that Lindenhurst Pediatrics does not file secondary insurance, but I am able to request a receipt to submit to Medicaid.
Insurance Name: _____

Subscriber Number/Member ID: _____

Group Number: _____

Policy Holder's Name: _____

Signature: _____

Printed Name: _____

Relationship to Patient: _____

Date: _____