Advanced
OBSTETRICS & GYNECOLOGY OF LAKE COUNTY, LLC

SHIVAKUMAR HANUBAL, M.D., F.A.C.O.G.
NATALIA ALEJANDRO, M.D., F.A.C.O.G.
NELLY RIVERA, M.D.
SHAWN LUNDBERG, APRN
TAMICHA GOODEN, APRN

MEDICAID PATIENTS WITH OTHER INSURANCE COVERAGE

Please initial each line below:

_____ **Benefits** - I understand if my records indicate that there may be ***another insurance policy***, this is your **Primary Insurance** benefits for this coverage must be filed ***before*** any Medicaid benefit.

_____ **Primary Insurance Change -** I must provide proof of termination for the **primary insurance** in no later than thirty (30) days if records indicate that there may be another insurance policy.

_____ **Charges** - If my insurance changes during my pregnancy the global fee is pro-rated and the appropriated charges are filed with the insurance plan which was in effect at the time of service.

I understand that I am responsible for providing updated information on any changes You are responsible for providing the termination letter from the primary to our office if you do not provide the information, we will not be able to file your Medicaid.

You have thirty (30) day to provide the termination letter from the Primary to our office.

If you believe there is an error you must contact Medicaid and make the corrections

_____ _____
Patient Signature Date