

G. Allen Bass, MD  
E. Randy Butler, MD  
Lauren N. Cates, NP  
William M. Darby, MD  
Mark A. DeMoss, MD  
Raymond W. Flanders, MD  
Lee S. Glenn, MD  
Hilary S. Humphries, MD



Shannon N. James, MD  
Jeanette Johnson-Watts, LMSW  
Michelle S. Lynch, MD  
Linda S. Parker, MD  
Michael R. Rupp, MD  
Patty T. Sanders, MD  
Laura K. Whitney, MD

## Patient Insurance Change

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# : \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# : \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# : \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# : \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# : \_\_\_\_\_

## Insurance Information

Name of Insurance Company: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

Group Number: \_\_\_\_\_

Policy/Subscriber Number: \_\_\_\_\_

Insurance Address to Mail Claims: \_\_\_\_\_

Insurance Company Phone #: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Policy Holder DOB: \_\_\_\_\_ Policy Holder SS#: \_\_\_\_\_

Policy Holder Employer Name: \_\_\_\_\_

The insurance information listed above is correct to the best of my knowledge.  
I also authorize the release of any medical information necessary to process claims.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

cmc-pa.com

ChildrensMedicalCenterPA

@CMCGreenville

703 Verdae Blvd.  
Greenville, SC 29607  
Tel: 864.288.5402  
Fax: 864.234.7961

112 Commons Blvd.  
Piedmont, SC 29673  
Tel: 864.295.8811  
Fax: 864.295.0806

307 North Main St.  
Simpsonville, SC 29681  
Tel: 864.228.8010  
Fax: 864.228.8050

841 South Buncombe Rd.  
Greer, SC 29650  
Tel: 864.877.1220  
Fax: 864.877.7731