# TOWN AND COUNTRY PEDIATRICS INSURANCE AUTHORIZATION

DATE: ______________________

For your insurance company's records

| Patient's name covered by this insurance | Date of Birth |
|---|---|
| _________________________ | ______________ |
| _________________________ | ______________ |
| _________________________ | ______________ |
| _________________________ | ______________ |

I have called my insurance company:______________________________
(Fill in insurance company name) to verify that Town and Country Pediatrics, S.C. is under contract and is in network. I understand that all balances not paid by my insurance company are my responsibility.

________________________________Responsible Party for Patient


Please drop this off at your child's Town and Country Pediatrics location or fax to:
Halsted office: 312-981-6312 or email officehalsted@townandcountrypeds.com
Glenview office: 847-998-8807 or email at officeglen@townandcountrypeds.com
Lincoln office: 773-478-4916 or email at officelinc@townandcountrypeds.com