Matthew J. Swanic, M.D.

9555 S. Eastern Avenue
Suite 250
Las Vegas, NV 89123

702.816.2525
702.586.3562 Fax
lveyeinstitute.com

Declaration of Medical Insurance

I,________________________________, verify that I have medical insurance coverage with the following companies:

Primary Insurance Company:____________________________________

Policy/ID Number:____

Secondary Insurance Company:__________________________________

Policy/ID number:____

If you are not the policy holder, please complete the following:

Policyholder's name: _________________________________

Policyholder's date of birth:_____________________________

Policyholder's employer:_______________________________

Las Vegas Eye Institute will make a good faith effort to bill the above primary and secondary insurance companies for services rendered.

I understand that if these insurance carriers do not make reimbursement, I will be responsible for medical fees.

It is not the responsibility of Las Vegas Eye Institute to verify coverage with these companies.

Signature________________________________Date:________________

Witness_________________________________Date:________________

***Do you have:**
Please Check One

Medicare______ Senior Dimensions______ Secure Horizons______