VALLEY REGIONAL SURGERY CENTER

DIRECT SCHEDULE FOR COLONOSCOPY

NAME: _____ DOB: _____

ADDRESS: _____

SS#: _____ PHONE: home _____

Cell: _____

Martial Status: _____ Place of employment: _____

Please look at your insurance card and give us the following information. This will enable us to correctly submit your claim.

Primary Insurance: _____ Insurance phone # _____

Insurance address: _____

Policy #/ID: _____ Group # _____

If you are not the policy holder then please provide

Name of Policy holder: _____ DOB: _____

Secondary Insurance: _____ Phone # _____

Address: _____

Policy #/ID: _____ Group# _____

Name of Policy Holder: _____ DOB: _____