**Personal Touch Medical Claims**
**3519 Scottywood Drive, Fayetteville, NC 28303**
**ptmclaims@gmail.com**
**704.576.9982 (fax) 888.476.4134**

# Insurance Form - Thrive

_____ _____
**Name of Patient** **Date of Birth**

_____ _____
**Address** **Phone Number**

_____
**City, State, Zip Code**

_____ _____
**Subscriber's Name** **Date of Birth**

_____ _____
**Name of Insurance** **Insurance Policy/ID #**

_____ _____
**Insurance Group #** **Insurance Phone Number**

I, _____ give Personal Touch Medical Claims (PTMC) permission to submit my medical claims to my insurance company for processing and/or reimbursement(s) to be sent directly to me. I am also in agreement to my financial responsibility of paying Personal Touch Medical Claims $8 per claim per month or $10 for more than two claims per month. I will submit payment to PTMC by ACH, CashApp, Venmo or Check/Money Order. I understand that my payment is due upon receipt of a notification or reference number indicating my claim(s) has/have been successfully submitted to my insurance company.

_____ _____
**Signature of Patient/Parent/Spouse** **Printed Name**

_____ _____
**Relationship to Patient** **Date**

Note: Payment information will be sent to you upon completion of this form. Once your insurance company has completed the overall processing of your claim, PTMC will also be finished with the process. If codes or errors are present and the claim(s) need to be corrected and resubmitted, PTMC will proceed. Thank you for choosing PTMC to serve your medical billing needs!