Return via fax: 303-524-6765
Attn: OMS

Otologic Management Services (OMS)
Patient Information Form
Baha or Cochlear Implant or Bilateral CI (circle one)

Center Name____

Tax ID#________________ NPI#______________ BCBS Provider #________________

Center Contact Name____________________________ Phone (____)______________

E-mail address____________________________________

Hospital where surgery will be performed____

Surgeon_____________________________ Patient diagnosis code(s) ________ ________

Patient Name____ Date of Birth________________

Address____________________________________City___________State______Zip_________

Sex: M F Home Phone (___) ______________

Relative or friend to contact for further information (if needed) ______________________________

Relative/Friend daytime phone (____) ____________

Referring physician______________________________________ Phone (___) ______________

Insurance Information (**Attach a photocopy of the patient's insurance identification cards**)

Primary insurance company__________________________________

Name of employer group ____

Certificate or ID#_________________________ Group #________________

Name of subscriber__________________________________ Subscriber SSN ________________

Address of insurance company ____

City_________________ State_____ Zip__________ Phone (___) __________

Secondary insurance company__________________________________

Name of employer group ____

Certificate or ID#_________________________ Group #____________

Name of subscriber__________________________________ Subscriber SSN ________________

Address of insurance company ____

City_________________ State_____ Zip__________ Phone (___) __________

Please attach any insurance correspondence to this form.

~6564830