

PRIMARY INSURANCE INFORMATION FOR

Name

PRIMARY INSURED

Circle if None

If Insured is same as Person Responsible for Bills there is no need to Re-enter Info., otherwise Complete below

First Name Middle Initials Last Name

Address Town State ZIP+4

Male Female Self Spouse Child Other

Date-of-Birth SSN Sex (Circle One) Relationship to Insured (Circle One)

Home Telephone Business Telephone Employer or School Name

PRIMARY INSURANCE (Circle One)

- 1. MEDICARE 2. MEDICAID 3. CHAMPUS 4. CHAMPVA 5. GHP 6. FECA 7. OTHER 8. NONE

Plan Name

What Type of Plan is this? (Circle the Applicable One if known) Managed Care Traditional

Insured's Policy Group or FECA Number Insured's ID Number (Often SSN) Account number (if

MISCELLANEOUS INFORMATION FOR INSURANCE PURPOSES

Condition Related to (Circle and Complete as applicable)

Employment Yes No Auto Accident Yes No Place-State ___ Other Accident Yes No

Date of current illness/trauma First date of same or similar illness

From To From To

Dates unable to work In current occupation Hospitalization dates related to current services

MEDICAID Only

Resubmission Code Original reference number Prior Authorization Number

Referring Physician name Referring Physician ID Number

Do you have a Second Insurance?

Yes Complete Secondary Insurance Page

No Complete Signatures Page