

Sindecuse Health Center
Division of Student Affairs
Patient Insurance Information

This form must be completed for Sindecuse Health Center to bill your insurance.

PATIENT (Please print)

Name _____ WIN # _____
Date of birth (MM/DD/YY) _____ Soc. Sec. # _____ Sex: M F
Local address _____ Phone (____) _____
City _____ State _____ ZIP _____

PRIMARY INSURANCE

POLICY HOLDER INFORMATION

Name _____ *Soc. Sec. # _____
Date of birth _____ Sex: M F Relationship to patient _____
Street address _____ Phone (____) _____
City _____ State _____ ZIP _____
Employer _____

INSURANCE INFORMATION

Insurance company name _____
Claim submission address _____
Contract/Policy # _____ Group # _____

**IF YOUR PRIMARY OR SECONDARY INSURANCE PLAN IS MEDICARE, MEDICAID, OR TRICARE,
PLEASE PROVIDE US WITH YOUR SECONDARY INSURANCE INFORMATION BELOW**

SECONDARY INSURANCE

POLICY HOLDER INFORMATION

Name _____ *Soc. Sec. # _____
Date of birth _____ Sex: M F Relationship to patient _____
Street address _____ Phone (____) _____
City _____ State _____ ZIP _____
Employer _____

INSURANCE INFORMATION

Insurance company name _____
Claim submission address _____
Contract/Policy # _____ Group # _____

**Required only if used by insurance company as contract/policy #*

I authorize Sindecuse Health Center to furnish information to my insurance carrier concerning my illness and treatments.

Patient (or Guardian) Signature _____ Date _____

Medicare Recipient:

I request that payment of authorized Medicare benefits be made on my behalf for services furnished me by Sindecuse Health Center. I authorize them to release medical information to the Center for Medicare and Medicaid Services or its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature _____ Date _____