

Patient Insurance Information

THIS FORM MUST BE COMPLETED FOR SINDECUSE HEALTH CENTER TO BILL YOUR INSURANCE.

PATIENT

| | |
|--------------------------|--|
| name (print) | WIN (WMU identification number) |
| date of birth (mm/dd/yy) | sex: <input type="checkbox"/> male <input type="checkbox"/> female |
| local address | phone |
| city | state ZIP |

1 Primary Insurance

POLICY HOLDER 1

| | |
|--------------------------|--|
| name (print) | relationship to patient |
| date of birth (mm/dd/yy) | sex: <input type="checkbox"/> male <input type="checkbox"/> female |
| local address | phone |
| city | state ZIP |
| employer | |

INSURANCE 1

| | |
|--------------------------|-----------------|
| insurance company | insurance phone |
| claim submission address | state ZIP |
| contract/policy number | group number |

2 Secondary Insurance

POLICY HOLDER 2

| | |
|--------------------------|--|
| name (print) | relationship to patient |
| date of birth (mm/dd/yy) | sex: <input type="checkbox"/> male <input type="checkbox"/> female |
| local address | phone |
| city | state ZIP |
| employer | |

INSURANCE 2

| | |
|--------------------------|-----------------|
| insurance company | insurance phone |
| claim submission address | state ZIP |
| contract/policy number | group number |

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

X _____ date
patient (or guardian) signature

**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.

X _____ date
patient signature