PLEASE PRINT CLEARLY

WESTERN MICHIGAN UNIVERSITY

(269) 387-3287
(269) 387-3204 fax

Patient Information

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

Patient

FULL LEGAL NAME (REQUIRED FOR HEALTH RECORDS)

WMU IDENTIFICATION NUMBER (WIN) IF KNOWN

DATE OF BIRTH (MM/DD/YY)

PREFERRED FIRST NAME AT WMU

LOCAL OR WMU ADDRESS

CITY

STATE ZIP

PHONE

SEX:
- ☐ FEMALE
- ☐ MALE

GENDER IDENTITY:
- ☐ FEMALE
- ☐ MALE
- ☐ TRANSFEMALE / MTF
- ☐ TRANSMALE / FTM
- ☐ TRANSGENDER
- ☐ GENDER NONCONFORMING
- ☐ DIFFERENT IDENTITY

Primary Insurance

☐ **USE AS PATIENT'S EMERGENCY CONTACT**

POLICY HOLDER 1

NAME

RELATIONSHIP TO PATIENT

DATE OF BIRTH (MM/DD/YY)

PHONE

ADDRESS

EMPLOYER

CITY

STATE ZIP

SEX: ☐ FEMALE ☐ MALE

INSURANCE 1

INSURANCE COMPANY

INSURANCE PHONE

CLAIM SUBMISSION ADDRESS

STATE ZIP

CONTRACT/POLICY NUMBER

GROUP NUMBER

Secondary Insurance or Emergency Contact

☐ **USE AS PATIENT'S EMERGENCY CONTACT**

POLICY HOLDER 2

NAME

RELATIONSHIP TO PATIENT

DATE OF BIRTH (MM/DD/YY)

PHONE

ADDRESS

EMPLOYER

CITY

STATE ZIP

SEX: ☐ FEMALE ☐ MALE

INSURANCE 2

INSURANCE COMPANY

INSURANCE PHONE

CLAIM SUBMISSION ADDRESS

STATE ZIP

CONTRACT/POLICY NUMBER

GROUP NUMBER

Patient Signature

I authorize Sindecuse Health Center to furnish information to my insurance carrier concerning my illness and treatments. **MEDICARE RECIPIENT AUTHORIZATION:** I request that payment of authorized Medicare benefits be made on my behalf for services furnished me by Sindecuse Health Center. I authorize Sindecuse Health Center to release to the Center for Medicare and Medicaid Services or its agents any information needed to determine these benefits or the benefits payable or related services.

X

PATIENT OR GUARDIAN SIGNATURE

DATE

Mail this form to: Sindecuse Health Center, Western Michigan University, 1903 W Michigan Ave, Kalamazoo, MI 49008-5445 or fax to (269) 387-4494.