INSURANCE INFORMATION FORM

TRUMAN STATE UNIVERSITY - STUDENT HEALTH CENTER

PLEASE COMPLETE, AT LEAST, THE AREAS INDICATED WITH RED PRINT.

Patient Name (Last, first, middle initial)	**Sex M F**	**Date of Birth**	**TSU ID # or SS #**
Local/Campus Address	**City/State**	**ZIP**	**Telephone No.**
Employer Name		Employer Telephone No.	
Employer Address (No. and Street, City, State and Zip)			
Spouse's Name	Spouse's Employer Name		Employer Tel. No.
Emergency Contact Name	**Relationship**		**Telephone No.**
Is this work related? Yes No	**Date Injury Occurred?**		

MEDICARE OR MEDICAID INSURANCE INFORMATION

Do you have Medicare? Yes No	**Is this an Auto Accident? Yes No**	**Telephone # of Agent**
Do you have Medicaid? Yes No Medicare No. Date effective thru?	**Name and Address of Auto Insurance**	**Policy No.**

PRIMARY INSURANCE

Insurance Company Name	**Name of Insured (Policy Holder)**	**Date of Birth of Insured**
Company Address	City/State	ZIP
Group No.	Insured's I.D./Certificate No.	
Relationship of Patient to Insured Self Spouse Child Other	**Social Security Number of Policy Holder**	

SECONDARY INSURANCE

Company Name	Name of Insured	**Date of Birth of Insured**
Company Address	City/State	ZIP
Group No.	Insured's I.D./Certificate No.	
Relationship of Patient to Insured Self Spouse Child Other	Social Security Number of Policy Holder	

BILLING

As a service to you, our charges will be filed with your insurance company by our billing service.

PROVIDE YOUR INSURANCE CARD TO THE PERSON AT THE FRONT DESK

AUTHORIZATION FOR DISCLOSURE TO INSURANCE

I hereby authorize the health center indicated above to furnish information to insurance carriers concerning my illness, condition and treatment, and I hereby irrevocably assign to the physician/health center all payments for medical services rendered to myself or my dependents. I understand that I am financially responsible and any charges not paid at time of service may be charged to my university account, unless billed to my insurance. Co-pays & any remaining balances will be charged to my university account after my insurance claim has been processed.

SIGNATURE _____ **DATE** _____