LABEL

NAME:_____R20

MINOR BILLING INFORMATION

Behavioral Health Services
Agnesian HealthCare

CC-80-28 **C** (9.12.18) ORDER FROM PRINTING

First name:_____ Middle initial: _____Last name:_____

Date of birth: _____ Phone number: _____

Mother's name: _____ Date of birth:_____

Address:_____ City: _____SS#: _____

Telephone: (home) _____ (work) _____(cell) _____

Father's name: _____ Date of birth:_____

Address:_____ City: _____ SS#: _____

Telephone: (home) _____ (work) _____ (cell) _____

INSURANCE INFORMATION

Name of insurance: _____

Policy holder's name: _____

Social security number of policy holder: _____ Birthdate of policy holder: _____

Is the insurance through a [ ] group or [ ] employer: _____

Address: _____

Pre-authorization: _____

_____

ID number: _____ Group: _____

Blue Cross: Group no.: _____ Identification no.: _____

WPS File no.: _____ Certification: _____

Medicare: Claim no.: _____

Medicaid: ID no.: _____

Effective dates: From: _____ Mo._____ /Day _____ /Yr. _____ to _____ Mo._____/Day _____/Yr._____

CC-0080