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:______________________________

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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._________