LABEL

NAME:_____

BILLING INFORMATION

Behavioral Health Services
Agnesian HealthCare

CC-80-28 NIS (9.19.18) ORDER FROM PRINTING

First name:_____Middle initial: _____ Last name: _____

Date of birth: _____ Phone number: _____

Date of contact: _____ Marital status: _____Maiden name: _____

Have you ever been here under another last name: _____SS#:_____

Address (city, state, zip): _____

Employer: _____ Address: _____Business phone: _____

Emergency contact:_____Phone: _____

Responsible party for payment if other than patient:

Name (last, first, middle initial): _____

Relationship to patient: _____

Address (city, state, zip): _____

Home phone number: _____ Employer: _____

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._____