

**BILLING
INFORMATION**
Behavioral Health Services
Agnesian HealthCare

CC-80-28 NIS (3.27.18) ORDER FROM PRINTING

LABEL

NAME: _____

Last name: _____ First name: _____ Middle initial: _____

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. _____



CC-0080