LABEL

NAME:____

BILLING INFORMATION

Behavioral Health Services
Agnesian HealthCare

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

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