

PATIENT ADMISSION HEALTH INSURANCE INFORMATION

Do you have a health insurance policy? _____ Yes _____ No

If you answered yes, you are required to complete the following information:

THIS INFORMATION IS PROTECTED UNDER THE PRIVACY ACT OF 1974.

Policy Holder's Name: _____ Policy Holder's SSN: _____

Patient's Name: _____ Patient's FMP: _____

Sponsor's Name: _____ Sponsor's SSN: _____

Policy Number: _____ Group Number: _____

Health Insurance Carrier: _____

Address: _____

City, State _____

Telephone: _____

PATIENT'S EMPLOYMENT STATUS (Check One) Employed: _____ Retired: _____

PATIENT

I certify that the above information is true and accurate to the best of my knowledge. I hereby authorize and request that proceeds of any and all benefits be paid directly to the Uniformed Service Facility or any other authorized representative of the United States for hospitalization and professional services provided me and/or my dependents.

SIGNATURE: _____

DATE SIGNED: _____

FOR OFFICIAL USE ONLY

REGISTER NUMBER: _____

DATE OF BIRTH: _____

TREATING DOCTOR: _____

DIAGNOSTIC CODE: _____

ROUTINE/EMERGENCY/SAME DAY SURGERY (CIRCLE ONE) _____

ADMISSION DATE: _____

REVIEWED BY: _____ **SIGNATURE:** _____

(PRINT NAME)