UNIVERSITY HEALTH SERVICES
University of Massachusetts Amherst
150 Infirmary Way
Amherst, MA 01003-9288
(413) 577-5192 Fax: (413) 577-5121

MR# _____
(for office use only)

INSURANCE INFORMATION

Complete and return to **UHS Patient Services** at the above address, or fax to (413) 577-5121 within 24 hours.

MEDICAL INSURANCE INFORMATION

Patient's name: _____ Date of birth: _____/_____/_____

Insurance company name: _____

Certificate / policy number: _____

Group name / plan: _____ Group #: _____

Insurance company address: _____
Street *City* *State* *Zip*

Subscriber's name: _____

Subscriber's address: _____
Street *City* *State* *Zip*

Effective date: _____/_____/_____

Relationship to subscriber *(check)*: _____ Self _____ Spouse _____ Dependent child

Does your insurance company require referrals: _____ Yes _____ No

Name of primary care provider (PCP): _____

Address: _____
Street *City* *State* *Zip*

Telephone #: _____–_____–_____

PRESCRIPTION INSURANCE INFORMATION

Rx processor name: _____ Rx help desk telephone #: _____–_____–_____
(Examples: Paid Prescriptions, Express Scripts, Medco)

BIN #: _____ PCN #: _____ ID #: _____ Rx group #: _____

Relationship to cardholder / person code: _____

MENTAL HEALTH INSURANCE INFORMATION

Policy #: _____

Insurance company name: _____

Claims address: _____
Street *City* *State* *Zip*

Telephone #: _____–_____–_____

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTY: I approve payment to UHS of all insurance benefits covering this visit. I agree that coordination of benefits will apply to all group insurance. I owe and agree to pay to UHS any and all charges not paid by insurance benefits. If my account is not paid, I will pay all court costs, attorney's fees, and other costs incurred by UHS.

Patient signature: _____ Date: _____/_____/_____ Witness: _____
(If patient is age 18 or over.)

Parent/Guardian signature: _____ Date: _____/_____/_____ Witness: _____
(If patient is age 18 or under.)

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Entered by: _____ Date: _____/_____/_____