

**UNIVERSITY HEALTH SERVICES**

University of Massachusetts Amherst  
150 Infirmery Way  
Amherst, MA 01003-9288

MR# \_\_\_\_\_

**INSURANCE INFORMATION**

Please complete and return to UHS **Patient Services** at the above address within 5 days or you will be directly billed for the services provided to you.

**MEDICAL INSURANCE INFORMATION**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 SS# \_\_\_\_-\_\_\_\_-\_\_\_\_

Subscriber's Address: \_\_\_\_\_  
Street City State Zip

Subscriber's Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Policy holder) SS# \_\_\_\_-\_\_\_\_-\_\_\_\_

Insurance Company Name / Address: \_\_\_\_\_  
 \_\_\_\_\_

Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insurance Company Telephone #: \_\_\_\_-\_\_\_\_-\_\_\_\_

**Member # / Policy#:** \_\_\_\_\_ **Group# or plan (if applicable)** \_\_\_\_\_

Relationship to Subscriber: Self \_\_\_\_ Spouse \_\_\_\_ Dep. Child \_\_\_\_ Other \_\_\_\_ Student \_\_\_\_

**MENTAL HEALTH INSURANCE INFORMATION**

Insurance Company Name: \_\_\_\_\_

Claims Address: \_\_\_\_\_  
 \_\_\_\_\_ Telephone #: \_\_\_\_-\_\_\_\_-\_\_\_\_

**RELEASE OF INFORMATION:** I hereby authorize the University of Massachusetts Health Services, to release medical and other such records pertaining to my visits to my above mentioned insurance company and any other insurers for the purpose of processing claims concerning my treatment. The undersigned releases the Health Services and its agents from all legal responsibility that may arise from the act authorized above.

**ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTY:** I approve payment to the University Health Services, 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 the University Health Services, for 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 the University Health Services.

**DISCLOSURE:** The undersigned hereby acknowledges receipt of a copy of this financial agreement on the date appearing below, and agrees to comply fully with all of its terms.

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

Signed \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Witness \_\_\_\_\_  
(Guardian signature: If patient is age 18 or under.)

White = Medical Record

Yellow = Billing

Pink = Patient