

Doctor:

Location:

Chart#

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Birth date: \_\_\_\_\_ Sex: M F

Patient's Social Security Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

County: \_\_\_\_\_ Phone Numbers: Home: \_\_\_\_\_

Work: \_\_\_\_\_ Cell: \_\_\_\_\_ Email address: \_\_\_\_\_

Marital Status: Single Married Divorced Widowed Race: \_\_\_\_\_

Employer/Retired/Unemployed: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Spouse Name: \_\_\_\_\_

Spouse's Social Security# : \_\_\_\_\_ Birth date: \_\_\_\_\_

Employer/Retired/Unemployed: \_\_\_\_\_ Work Number: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone # Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Are you a resident of a skilled nursing facility or receiving care under hospice benefits? Yes No

Facility Name and Address: \_\_\_\_\_

Facility Phone#:

Do you have a primary care physician? Y N NA If yes, name and address / phone: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ADULT PCP/SPECIALTY

**PRECERTIFICATION AND REFERRALS**

If your insurance company requires preadmission certification or office referrals, it is your responsibility to see that we notify your insurance company prior to all admissions or office visits. Any charges not covered as a result of non-certification will be your responsibility.

Patient's Signature: \_\_\_\_\_

**OFFICE FINANCIAL POLICY**

INSURANCE AUTHORIZATION: I request that payment under the medical insurance program be made to the provider for any bills for services rendered to me during the effective period of this authorization. I authorize this provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or related Medicare claim. I further permit a copy of this authorization to be used in place of the original. This authorization is to apply to all private insurance claims submitted by the provider on my behalf.

Patient's Signature: \_\_\_\_\_

I am responsible for all financial obligations of health services for the above patient, and for reimbursement and payment of claims from my insurance company. I am responsible for providing the name of the preferred hospital, laboratory or any other preferred facility / physician in network with the insurance plan to Memorial Health University Physicians. If for any reason the account should become delinquent, I agree to pay for all rebilling charges, collection costs, and reasonable legal fees.

Responsible Party's Signature: \_\_\_\_\_

***Please remember, it is the patient's responsibility to complete and update this information as needed. Any charges incurred due to incorrect information will be the patient's responsibility.***

**Name of Primary Insurance Plan:** \_\_\_\_\_

Please check appropriate boxes: Group Private Medicare Supplement Medicare  
Medicare Advantage Medicaid Medicaid HMO Worker's Compensation Cancer Tricare

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ Subscriber Birth date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Subscriber Sex: M F

Address to mail claim: \_\_\_\_\_

Does your primary insurance require referral numbers? Yes No Phone Number: \_\_\_\_\_

Does your primary insurance require pre-certification? Yes No Phone Number: \_\_\_\_\_

If your insurance does not allow use of Memorial's Lab, what is the preferred lab? \_\_\_\_\_

**Name of Secondary Insurance Plan:** \_\_\_\_\_

Please check appropriate boxes: Group Private Medicare Supplement Medicare  
Medicare Advantage Medicaid Medicaid HMO Worker's Compensation Cancer Tricare

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ Subscriber Birth date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Subscriber Sex: M F

Address to mail claim: \_\_\_\_\_

Does your secondary insurance require referral numbers? Yes No Phone Number: \_\_\_\_\_

Does your secondary insurance require pre-certification? Yes No Phone Number: \_\_\_\_\_

Who is your secondary insurances preferred lab? \_\_\_\_\_

**Do you have prescription coverage?** Yes No Program Name: \_\_\_\_\_

**IF YOU HAVE MEDICARE COVERAGE OR ARE ELIGIBLE FOR MEDICARE PLEASE COMPLETE QUESTIONS BELOW:**

Are you still working? Yes No Retirement Date: \_\_\_\_\_

Do you have an employer group health coverage? Yes No Number of Employees \_\_\_\_\_

Is your spouse still working? Yes No Retirement Date: \_\_\_\_\_

Are you covered through your spouse's insurance? Yes No Number of Employees \_\_\_\_\_

The signature below serves as authorization for medical treatment by the physician, physician's assistant, nurse practitioner, or nurse for the named patient. It also provides authorization for this Memorial Health University Physician to furnish and/or release any information necessary to insurance carriers, third party administrators, self-insured plan administrator, and/or other health benefit payer representatives in order to process health care claims incurred at this office or for utilization review or quality assurance.

PATIENT \_\_\_\_\_ DATE \_\_\_\_\_