CEDARVILLE UNIVERSITY™

Patient Insurance Information Sheet

Student's last name (please print) | First name | Middle name | Date of birth (month/day/year) | ❑ M ❑ F Sex

Home address (number and street) | City | State | Zip | Country

Cedarville University student ID number | Campus P.O. box number | Cell phone number

Person to contact in case of emergency | Relationship (parent, guardian, spouse) | Phone number

- ❑ No private medical insurance: CU student insurance is PRIMARY [Complete Sections 3, 4, 5]
- ❑ Private medical insurance is PRIMARY: CU student insurance is SECONDARY [Complete Sections 1, 3, 4, 5]
- ❑ Private medical insurance is SECONDARY: CU student insurance is PRIMARY [Complete Sections 2, 3, 4, 5]
- ❑ Private medical insurance is PRIMARY/Additional private medical insurance SECONDARY: CU student insurance is TERTIARY [Complete Sections 1, 2, 3, 4, 5]

SECTION 1: PRIMARY MEDICAL INSURANCE

Name of policyholder/subscriber | Policyholder/Subscriber date of birth

Insurance company name | Address | City | State | Zip

Policyholder/Subscriber identification number | Group number | ❑ Child ❑ Self ❑ Spouse ❑ Other Relationship of patient to policyholder/subscriber

SECTION 2: SECONDARY MEDICAL INSURANCE

Name of policyholder/subscriber | Policyholder/subscriber date of birth

Insurance company name | Address | City | State | Zip

Policyholder/Subscriber identification number | Group number | ❑ Child ❑ Self ❑ Spouse ❑ Other Relationship of patient to policyholder/subscriber

SECTION 3: MEDICARE OR MEDICAID INSURANCE INFORMATION

Do you have Medicare? ❑ Yes ❑ No Medicare number_____ Date effective through _____

Do you have Medicaid? ❑ Yes ❑ No Medicaid number_____ Date effective through _____

SECTION 4: BILLING

Who is responsible for your bill? You and ❑ Parent(s) ❑ Spouse As a service to you, UMS charges will be filed with your private insurance company by our billing service.

Present your insurance card to the front office staff at time of appointment.

SECTION 5: PATIENT AUTHORIZATION

I hereby authorize UMS to furnish information to insurance carriers concerning my illness, condition, and treatment, and I hereby irrevocably assign to the physician/health center all payments for medical services rendered to myself or my dependents. I understand that I am financially responsible for all charges that may be charged to my student health account.

Signature of patient | Date

Signature of parent or guardian **IF STUDENT IS UNDER AGE 18** | Date