INSURANCE INFORMATION FORM

TRUMAN STATE UNIVERSITY - STUDENT HEALTH CENTER

PLEASE COMPLETE, AT LEAST, THE AREAS INDICATED WITH RED PRINT.

Patient Name (Last, first, middle initial)	**Sex M F**	**Date of Birth**	**TSU ID #**
Local/Campus Address	**City/State**	**ZIP**	**Telephone No.**
Permanent Home Address			
Spouse's Name	Spouse's Employer Name		Employer Tel. No.
Emergency Contact Name	**Relationship**		**Telephone No.**

MEDICARE OR MEDICAID INSURANCE INFORMATION

Do you have Medicaid? Yes No	**Is this an Auto Accident? Yes No**	**Telephone # of Agent**
The University's Student Health Center is not a Medicare/Medicaid provider. Indigent plans are available for qualified patients.	**Name and Address of Auto Insurance**	**Policy No.**

PRIMARY INSURANCE

Insurance Company Name	**Name of Insured (Policy Holder)**	**Date of Birth of Insured**
Company Address	City/State	ZIP
Group No.	Insured's I.D./Certificate No.	
Relationship of Patient to Insured Self Spouse Child Other		

SECONDARY INSURANCE

Company Name	Name of Insured	Date of Birth of Insured
Company Address	City/State	ZIP
Group No.	Insured's I.D./Certificate No.	
Relationship of Patient to Insured Self Spouse Child Other		Social Security Number of Policy Holder

BILLING

As a service to you, our charges will be filed with your insurance company by our billing service.

PROVIDE YOUR INSURANCE CARD TO THE PERSON AT THE FRONT DESK

AUTHORIZATION FOR DISCLOSURE TO INSURANCE

I hereby authorize the health center indicated above 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 and any charges not paid at time of service may be charged to my university account, unless billed to my insurance. Co-pays & any remaining balances will be charged to my university account after my insurance claim has been processed.

SIGNATURE _____ **DATE** _____