Health Insurance Information Sheet

Every participant must have this form on file

Private insurance information must be provided, if applicable. If a participant does not have private health insurance, please be advised that, should a participant require medical attention, **you are responsible for paying any costs not covered by insurance.**

Participant Name _____SS Number_____

Address_____

Phone Number_____ Date of Birth_____

Insurance Company Name_____ Effective Date_____

Address of Insurance company_____

Phone Number of Insurance Company_____ Group #_____

Policyholder's name Policy #_____

Policy holders address (if different from above)_____

Relationship to participant _____

Contract # _____Employee number_____

Name and phone number of Primary Care Physician

_____

I hereby authorize the release of any medical information, which might be needed in connection with payment for medical services

Participant Signature_____ Date_____

Parent/Guardian Signature _____ Date_____

I request that payment under my medical insurance program be made directly to the provider on any bills for services rendered by that provider. I understand that I am financially responsible for fees not covered by this authorization

Participant Signature_____ Date_____

Parent/Guardian Signature _____ Date_____