Patient Insurance Information

Patient Name:_____ MR#:_____ SOC:____/____/_____

Select Insurance Type:

☐ ***Blue Cross Blue Shield***

Blue Cross Blue Shield of _____ Subscriber Name:_____
(State)

Group Number:_____ BC Plan Code:_____ Contract Number:_____

☐ ***Medicare***

Health Insurance Social Security Act

Name of Beneficiary:_____ Sex:_____ Claim Number:_____

Entitled To: ☐ Part A ☐ Part B Effective Date:_____

Part A:_____ Part B:_____

☐ ***Medicaid***

*Recipient ID#:_____ *Eligible Person:_____ *DOB:_____

*OI:_____ Medical Assistant Authorization:____/____/_____ thru ____/____/_____ PROG: _____

CO:_____ DIST:_____ UNITS:_____ WKS:_____ Case Manager: _____

*Scope of Coverage:_____ Patient Pay Amount: _____

*Level of Care:_____

*** Required Information**

☐ ***Other Private Insurance***

Name of Subscriber:_____ Self ☐ Spouse ☐

Contract Number:_____ Group Number:_____

Is the Patient:

YES	NO	
☐	☐	Under 65 yrs. of Age?*
☐	☐	Or Spouse currently working with other insurance coverage?*
☐	☐	Receiving care due to an accident?*
☐	☐	Enrolled in the black lung program, a government research or veteran program?*
☐	☐	Undergoing kidney dialysis?*
☐	☐	Pending application for Medicaid or Crippled Children's?*
☐	☐	Being seen by another agency or outpatient therapy?*

If Yes, Agency Name:_____ Start Date:_____ D/C Date:_____

☐ Transfer Form Completed D/C Call Made:_____ By:_____

***Please Note: If Yes, complete appropriate section in Medicare Secondary Payor Questionnaire**

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White Copy - Office Yellow Copy - Patient