

Health Care—Source of Payment

NAME: _____

Date of birth: _____

DO YOU HAVE HEALTHCARE INSURANCE? YES NO (circle one)

If *YES*—fill out the requested information.

In the space provided, write your insurance provider’s name and contact information. If you get a new provider or have more than one provider, write the information in the next available space. Remember to include dental, eye and prescription insurance on this form.

INSURANCE PROVIDER and phone number	Identification Number	What Does it Cover	Insurance Contact Address for Billing Purposes (often on back of card)
NAME: PHONE #:			
NAME: PHONE #:			
NAME: PHONE #:			
NAME: PHONE #:			
NAME: PHONE #:			

DO YOU HAVE MEDICAID BENEFITS? YES NO (circle one)

If *YES*—fill out the requested information.

In the space provided, write your Medicaid identifying information and contact information.

MEDICAID

Identification Number	Medicaid Phone Number	Medicaid Contact Address

NOTE: You can apply for Medicaid in any one of the following ways—write, phone, or go to your local department of social services.

DO YOU HAVE MEDICARE BENEFITS? YES NO (circle one)

If *YES*—fill out the requested information.

In the space provided, write your Medicare identifying information and contact information.

MEDICARE

Identification Number	Medicare Phone Number	Medicare Contact Address

IS THERE ANY OTHER SERVICE PROVIDING HEALTHCARE PAYMENTS FOR YOU?

YES NO (circle one)

If *YES*—fill out the requested information.

In the space provided, write your health care payment provider's identifying and contact information.

Provider's Name	Identification Number	Provider's Phone Number	Contact Address