

UMD HEALTH SERVICES
PATIENT INSURANCE AND BILLING FORM

PATIENT INFORMATION

Student ID#: _____

Patient's Name: _____

(please print)

Patient's Local Address OR

Residence Hall & Room Number: _____

(include zip code) _____

Patient's Cell Number: _____

(if no cell, local number)

Date of Birth: _____

Age: _____

Male _____ Female _____

INSURANCE COVERAGE: CHECK ONE

University Plans:

Student Health Benefit Plan _____

Academic Health Center Plan _____

Graduate Assistant Plan _____

Other Insurance _____

(must complete information below)

Insurance Company Name _____

Policy Holder's Name _____

Policy Holder's Date of Birth _____

Policy Holder's ID # _____

Group # _____

Insurer's Phone Number _____

Self Pay _____

(An itemized statement will be sent to you or, at your request, to your parents. It is your responsibility to process the claim directly with your insurance company.)

BILLING ADDRESS INFORMATION

Charges not covered by insurance are the responsibility of the patient. Statements should be sent to the following address:

Local Address (listed above) _____

OR

Name: _____

Relationship to Patient: _____

Address: _____

Phone Number: _____