Patient Insurance Information

*This information is stored in the TAMS Student Life Office and McConnell Hall in the case of an emergency requiring medical attention from a Hospital, pharmacy or non-campus medical entity.

Patient/Student Information

Name: _____ Social Security Number: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone #: _____ Date of Birth: _____ Sex: _____
Full Time Student ___X___

RETURN COMPLETED FORM WITH FRONT AND BACK OF CURRENT INSURANCE CARD

Primary Insurance Information

PARENT/SPOUSE INFORMATION (The person that carries the insurance for you)

Name: _____ Social Security Number: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone #: _____ Date of Birth: _____ Sex: _____ Marital Status: _____
Employment Status: Full Time _____ Retired/Date _____
Employer Name: _____ Occupation: _____
City: _____ State: _____ Zip: _____ Phone: _____
Primary Insurance Company: _____ Group Number: _____
Insurance Address: _____ Insurance Phone Number: _____

Secondary Insurance Information

PARENT/SPOUSE INFORMATION (The person that carries the insurance for you)

Name: _____ Social Security Number: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone #: _____ Date of Birth: _____ Sex: _____ Marital Status: _____
Employment Status: Full Time _____ Retired/Date
Employer Name: _____ Occupation: _____
City: _____ State: Zip: _____ Phone: _____
Primary Insurance Company: _____ Group Number:
Insurance Address: _____ Insurance Phone Number: _____

Patient Long-Term Signature Authorization

I hereby authorize the release of any medical accounting information necessary to process my medical insurance claim. I understand that claims will be charged at the usual and customary rate for medical tests and office visits. I understand the specific information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I authorize the release of this specific data. I also understand that this authorization may be revoked by the person giving authorization by written and dated notice, except to the extent that disclosure of information has been made prior to receipt of the revocation. I further permit copies of this authorization to be used in place of the original.

Term of Authorization: From date executed below until May 12, 2017.

Insurer Signature: _____ Date: _____

Please understand that this information does not apply to services rendered under the care of the UNT Health Center. A separate insurance plan from UNT must be purchased to cover services received from UNT facilities.

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