



INSURANCE INFORMATION

* CLIENT: _____
 * LAST NAME _____ * FIRST NAME _____ Middle _____

* TYPE OF INSURANCE: PRIMARY SECONDARY TERTIARY FUNDED / OTHER

* TYPE OF INSURANCE COVERAGE: INDIVIDUAL FAMILY N/A

* INSURANCE PROVIDER:

MEDICAID SNP (AMIDA CARE) PRIVATE / COMMERCIAL BLUE CROSS
 MEDICAID FHPLUS HMO / MANAGED CARE (PRIVATE) BLUE SHIELD
 MEDICAID CHPLUS SELF PAY OTHER
 MEDICARE / MEDICAID HIV UNINSURED CARE PROGRAMS / ADAP, ADAP PLUS HEPCAP
 MEDICAID FEE-FOR-SERVICE MILITARY / VA MEDICAID SNP (MetroPlus)
 MEDICAID MCO (MAINSTREAM) MEDICAID PENDING MEDICAID SNP (SelectHealth)
 MEDICARE WORKERS COMPENSATION

Policy Number: _____ Sequence #: _____

Group Number: _____ Description: _____

* EFFECTIVE DATE: ____ / ____ / ____ Expiration Date: ____ / ____ / ____
 MONTH DAY YEAR Month Day Year

Deductible: \$ _____ Left: \$ _____

Co-Payment Type: Percentage Coverage Co-Payment Amount Amount By Service N/A

Co-Payment Owed: _____ % Covered: _____ Employer: _____

Related To Insured:

<input type="checkbox"/> 01 Significant Other	<input type="checkbox"/> 11 Uncle	<input type="checkbox"/> 22 Employer	<input type="checkbox"/> 32 Neighbor
<input type="checkbox"/> 02 Spouse	<input type="checkbox"/> 12 Aunt	<input type="checkbox"/> 23 Friend	<input type="checkbox"/> 33 Social / Case Worker
<input type="checkbox"/> 03 Son	<input type="checkbox"/> 13 Foster Parent	<input type="checkbox"/> 24 In-Law	<input type="checkbox"/> 34 Coworker
<input type="checkbox"/> 04 Daughter	<input type="checkbox"/> 14 Foster Child	<input type="checkbox"/> 25 Methadone Counselor	<input type="checkbox"/> 35 Needle Sharing Partner
<input type="checkbox"/> 05 Mother	<input type="checkbox"/> 15 Step Parent	<input type="checkbox"/> 26 Roommate	<input type="checkbox"/> 36 Sex Partner
<input type="checkbox"/> 06 Father	<input type="checkbox"/> 16 Step Child	<input type="checkbox"/> 27 Sponsor	<input type="checkbox"/> 37 Non Injection Drug Use Partner
<input type="checkbox"/> 07 Brother	<input type="checkbox"/> 17 Niece	<input type="checkbox"/> 28 Therapist / Counselor	<input type="checkbox"/> 38 Domestic Partner
<input type="checkbox"/> 08 Sister	<input type="checkbox"/> 18 Nephew	<input type="checkbox"/> 29 Clergy	<input type="checkbox"/> 39 Ex-Lover
<input type="checkbox"/> 09 Grandparent	<input type="checkbox"/> 20 Other Relative	<input type="checkbox"/> 30 Ex-Spouse	<input type="checkbox"/> 99 Other
<input type="checkbox"/> 10 Grandchild	<input type="checkbox"/> 21 Cousin	<input type="checkbox"/> 31 Doctor - Med. Provider	

Name Of Insured: _____ Date Of Birth: ____ / ____ / ____ Sex: Male Female
 Month Day Year

Street: _____ City: _____ State: _____

Zip Code: _____

Will Physician Accept Assignment? Yes No N/A

Is Patient Medicare Eligible? Yes No N/A

Is Patient Signature On File? Yes No N/A

Rate Group: FUNDS Budget Fund Rates (Not Billed To Ins., For Budget) MCD01 Medicaid Default Rates
 GHI01 GHI Default Rates MCD02 Medicaid 2 Rates (Income < \$10,000 YEAR)
 HIP01 HIP Default Rates MCD03 Medicaid 3 Rates (\$10,000 > Income < \$20,000)
 INTER Internal Agency Default Rates MDC04 Medicaid 4 Rates (\$20,000 > Income < \$30,000)
 RATE 1 Rate Group 1 REGUL Regular Insurance Rates (For Oxford & BHP)
 RATE 2 Rate Group 2