UNIVERSITY HEALTH SERVICES
150 Infirmary Way
University of Massachusetts
Amherst, MA 01003-9288

MR# ______________________________

INSURANCE INFORMATION

Please complete and return to UHS **Patient Services** at the above address within 5 days or you will be directly billed for the services provided to you.

MEDICAL INSURANCE INFORMATION

Patient Name ______________________________ Date of Birth_____/_____/_____
SS#_____/_____/_____

Permanent Address: ______________________________

Subscriber's Name: ______________________________ Date of Birth_____/_____/_____
(Policy holder) SS#_____/_____/_____

Subscriber's Employer: ______________________________

Insurance Company Name/Address: ______________________________

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Effective Date:_____/_____/_____ Telephone #:_____–_____–_____

Certificate/Policy#: ______________________ **Group# or plan (if applicaple)** ______________________

Relationship to Subscriber: Self_____ Spouse_____ Dep. Child_____ Other_____ Student_____

Does this replace other insurance previously submitted to UHS? Yes_____ No_____

MENTAL HEALTH INSURANCE INFORMATION

Insurance Company Name: ______________________________

Claims Address: ______________________________

______________________________ Telephone #:_____–_____–_____

RELEASE OF INFORMATION: I hereby authorize the University of Massachusetts Health Services, to release medical and other such records pertaining to my visits to my above mentioned insurance company and any other insurers for the purpose of processing claims concerning my treatment. The undersigned releases the Health Services and its agents from all legal responsibility that may arise from the act authorized above.

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTY: I approve payment to the University Health Services, of all insurance benefits covering this visit. I agree that coordination of benefits will apply to all group insurance. I owe and agree to pay to the University Health Services, for any and all charges not paid by insurance benefits. If my account is not paid, I will pay all court costs, attorney's fees, and other costs incurred by the University Health Services.

DISCLOSURE: The undersigned hereby acknowledges receipt of a copy of this financial agreement on the date appearing below, and agrees to comply fully with all of its terms.

Signed______________________________ Date:_____/_____/_____ Witness______________________________
(Patient signature: If patient is age 18 or over.)

Signed______________________________ Date:_____/_____/_____ Witness______________________________
(Guardian signature: If patient is age 18 or under.)

White = Medical Record Yellow = Billing Pink = Patient