Policy #________________________ Effective Date:____________________

GROUP NAME__________________ GROUP # __________________

Insurance Company Name & Address: Phone #_________________________

______________________________ Medical Coverage:_________________

______________________________ Dental Coverage:__________________

______________________________ Pharmacy Coverage:_______________

Self or Family Coverage (circle one)

Does this PT have Medicare? YES___NO_____
If yes, is the Medicare PRIMARY over PI? YES_____ NO________
Does PT have more than one insurance policy? YES_____ NO______
If yes, which is PRIMARY? _____________________________
Is the PT the policy holder? YES______NO _________

Policyholder's Name & Address:

______________________________ Sex_________ DOB ____________

______________________________ SSN#___________________________

______________________________ Phone___________________________

Policy Holder's Employers Name & Address:

______________________________ Phone___________________________

______________________________ Employment Status Full Time/Part Time

____

Patient's Name	Relationship to insured	Chart Number
______________________________	____________________	___________

Other Family Members with Charts at CIH who are covered under this insurance.

______________________________	____________________	___________
______________________________	____________________	___________
______________________________	____________________	___________
______________________________	____________________	___________

ATTACH COPY OF CARD & RELEASE TO WORKSHEET.
MAKE COPIES FOR ALL FAMILY MEMBERS, MAKE SURE ALL INFO IS COMPLETE & MAKE PI CHARTS.

INTITIAL BY_________

DATE RCV'D________