UCR SCHOOL OF MEDICINE
Medical Student Insurance Information

Patient Information

Name

aka:

Home Phone ( )

Work/Msg. Phone ( )

Email

Address

City

State Zip Code

Student ID#

D.O.B. Age

Marital Status Sex

Employer Information

Employer

Address

City

State Zip Code

Phone ( )

Duration _____ Years Still Employed? yes____ no____

Occupation

Emergency Notification

Name

Phone ( )

Relationship

Insurance Information

HMO/PPO/Commercial/Other

Cash Pay ☐ No Insurance ☐

Insurance Co./Med Group

Phone #:

Insurance Card #

Group #

Address

City

State Zip Code

Phone ( )

Insured

D.O.B.

Employer

Phone ( )

Occupation

Primary Care Physician Information

PCP:

Phone ( )

Address

Insurance Benefit Information (Office Use Only)

Benefit Type: Mental Health ☐ Chemical Dependency ☐ (Check One)

Effective Date of Insurance

Secondary Ins. Exist: Yes No

Pre-Certification Required Yes No

Company

Phone ( )

Contact Person

Authorization #

I/P Detoxification

I/P Rehabilitation

I/P Psychiatric

Partial Full/Half Day

IOP **Psych CD**

Cal Yr Max Ltm Max

Co-Payment (% or $)

Max Out-of-Pocket

Ded Per Yr Ded Met to Date

Benefit Yr (Circle One) Calendar / Benefit