University of Iowa
Student Health & Wellness
INSURANCE INFORMATION

Name _____

Birth Date _____

Student ID#_____

PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD

I. Employer of Policyholder: _____

Primary Policyholder Information:

Name of Policyholder: _____
Address of Policyholder: _____
(Street) (City) (State) (Zip)
Phone of Policyholder: (_____) _____--_____
Birth Date of Policyholder: _____/_____/_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Partner ☐ Father ☐ Mother ☐ Other_____

Primary Insurance Information:

Insurance Company: _____
Address of Insurance Co: _____
Phone Number(s): (_____) _____--_____; (_____) _____--_____
Policy Number: _____
Group Number: _____

****Do you have other health insurance?** ___Yes ___ No If yes, please complete the following information:

II. Employer of Policyholder: _____

Secondary Policyholder Information:

Name of Policyholder: _____
Address of Policyholder: _____
(Street) (City) (State) (Zip)
Phone of Policyholder: (_____) _____--_____
Birth Date of Policyholder: _____/_____/_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Partner ☐ Father ☐ Mother ☐ Other_____

Secondary Insurance Information:

Insurance Company: _____
Address of Insurance Co: _____
Phone Number(s): (_____) _____--_____; (_____) _____--_____
Policy Number: _____
Group Number: _____

WE RECOMMEND THAT YOU HAVE YOUR INSURANCE CARD WITH YOU AT SCHOOL

Return this form to:
Mail: University of Iowa, Student Health & Wellness
4189 Westlawn, Iowa City, IA 52242-1100
Fax: 319-335-7247
Email: student-health@uiowa.edu

For questions visit our website at http://studenthealth.uiowa.edu/ or call 319-335-8370

The University of Iowa Hospitals and Clinics

Authorization for Release of Information and Payment Request

Hospital Number: _____ Name: _____ Student ID: _____

A. Insurance, payment information and assignment of benefits

I request the University of Iowa Hospitals and Clinics (UIHC) and/or its affiliates and the Faculty Practice Plan to submit claims on my behalf to my insurance company, Medicare, or other third party payor for my care and authorize disclose of health information to the extent necessary to obtain payment for the hospital and/or physician services.

- In consideration of the health care services provided to the Patient, I assign and authorize my insurance company, Medicare, or other third party payor to make payments directly to the University of Iowa Hospitals and Clinics including charges for physician services.
- In consideration of the health care services provided to the Patient, I assign to the University of Iowa Hospitals and Clinics any medical benefits to which I may be entitled to receive, including without limitation any such benefits due or claims I have under or pursuant to a health care employee benefit plan, governed under ERISA, 29 USC sec. 101 et seq.
- I have been informed that:
  - I must pay all charges, co-payments, deductibles, and coinsurance not covered by my insurance company, Medicare, or third party payor.
  - I must pay all charges incurred if I lack insurance coverage and will also contact UIHC to work with them to identify financial options available for me.
  - This release includes ambulance providers and their agents who transported the patient to UIHC for the purpose of attempting to secure payment for their services.
  - I may revoke this consent to release medical information at any time by sending a written notice to Joint Office of Patient Financial Services, University of Iowa Hospitals and Clinics, 200 Hawkins Drive, Iowa City, Iowa 52242. Except as provided below * this release is valid until revoked.
- I agree to pay for non-covered services or services not covered as a result of my failure to obtain pre-authorization for treatment as required by any such payor, or agreed upon services deemed as medically unnecessary by the payor.
- UIHC will use good faith efforts to protect patient's right to confidentiality in appropriately providing health information to payers.

B. Specific Authorization for Release of Information

- I specifically authorize UIHC to submit medical information regarding diagnoses, treatment, consultations, prescriptions, and medical history to my insurance company, Medicare, or other third party payor or its authorized agents or representatives for the purpose of determining benefits and facilitating payment. This authorization is valid for one (1) year*. Disclosures may only be made pursuant to the written authorization of an individual or an individual's legal representative. The unauthorized disclosure of this information is unlawful and civil damages and criminal penalties may be applicable to the unauthorized disclosure of said information pursuant to the Iowa code. I may revoke this specific consent to release information at any time by sending a written notice to Joint Office of Patient Financial Services, University of Iowa Hospitals and Clinics, 200 Hawkins Drive, Iowa City, Iowa 52242. I understand that the information to be released may include information in the following categories unless I specifically deny the release (***initial*** any category ***not*** to be released).

_____ Substance Abuse

_____ Acquired Immune Deficiency Syndrome (AIDS) including Human Immuno-deficiency Virus (HIV)

_____ *Mental Health (valid for two years)

_____	_____	_____
Patient Signature/Responsible Person	Date Signed	Relationship/Legal Title (if not patient)
_____	_____	_____ _____
Witness	Date Signed	Witness Date