University of Iowa Student Health
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

Front of Insurance Card	**Back of Insurance Card**

Hosp. #_____

University of Iowa Hospitals & Clinics (UIHC)
Patient Financial Services
200 Hawkins Dr., Iowa City, IA 52242 (Fax: 319-356-2862)

A&A – Authorization to Bill Insurance (Release of Information and Payment Request)

Patient Name _____ **Birth Date** _____

A. Insurance, Payment Information and Assignment of Benefits:

I request the University of Iowa Hospitals & 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 disclosure 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 UIHC including charges for physician services.
- In consideration of the health care services provided to the patient, I assign to UIHC 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.
  - Failure to sign this authorization may result in denial of payment.
- 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:

This consent is voluntary. If I cancel this consent at a later date, I must send written notification to the above address. If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the Director of Health Information Management at the above address. I have been offered a copy of this authorization.

UIHC does not require completion of this form as a condition of evaluation or treatment. However, when the requested evaluation or treatment is solely for the purpose of creating a medical report for a third party, if authorization to release the information to that third party is not provided, it may result in the cancellation of those services. I understand that the information may be released electronically, and may include information in the following categories unless I specifically deny the release **(*initial* any category *not* to be released)**.

Substance Abuse* _____ Mental Health _____ HIV-related information _____ Genetic tests/info**_____

*****Information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2 prohibits unauthorized disclosure of these records). ******Refers to genetic testing to screen for possible future health issues, does not refer to testing to diagnose or treat current health conditions.

This agreement allows release of past and future information and will expire two years from the date of signature, or as indicated (specify number of days or months) _____ unless cancelled by the patient/guardian.

_____	_____	_____
Signature of Patient or Legal Guardian	Printed name	Date

_____	_____
Relationship, if Not the Patient	Witness Signature