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

Return this form to:
Mail: University of Iowa Student Health
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

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1/08, Rev. 7/09, 11/09, 05/13, 9/13, 10/13, 5/14/15, 2/19/19

Hospital #: ____________

A&A – AUTHORIZATION TO BILL AND AUTHORIZATION TO RELEASE OF INFORMATION FOR PAYMENT

(Insurance and/or Employer for Occupational Health Services)

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

Patient legal name: ______________________________ **Birth date:** ______________

A. Insurance, Payment Information, and Assignment of Benefits:

I request the University of Iowa Health Care 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 U.S. Code § 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 payors, including review for active coverage not previously communicated to UIHC in order to seek payment on behalf of the patient.

B. Payment Information for Employment Related Occupational Health Services:

I request the University of Iowa Health Care and/or its affiliates to bill the employer for all associated costs for evaluation or treatment related to Occupational Health services and will submit claims on my behalf to our workers' compensation insurance carrier, if appropriate. I authorize disclosure of health information to the extent necessary to comply with employee/employer requirements to obtain payment for Occupational Health services.

C. 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 Director of Health Information Management at 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. I understand there may be a charge for this information.

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 **(*check* 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 UIHC information and will expire 2 years from the date of signature, or as indicated (specify number of days or months) __________________________ unless cancelled by the patient/guardian.

Signature: ____ **Date:** ______________________
(Patient or person legally authorized to consent for patient)

____ ______________________
(Printed name of legally authorized person signing) (Relationship of legally authorized person)

____
(Witness signature, only required when patient or person legally authorized is physically unable to sign)