JASPER MOUNTAIN
Hope for Children & Families

MEDICAL RESOURCES

Return the completed form and copies of insurance cards (*front and back*) to Jasper Mountain

For each *Insurance Policy*, complete a section.

PATIENT INFORMATION

Child's Name (Last, First, Middle Initial):_____

Date of Birth: _____ Social Security Number: _____ Gender: M F

Home Address: _____

Home Phone: _____

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient (Circle one): Parent Other

Name (Last, First, Middle Initial): _____

Date of Birth: _____ Social Security Number: _____ Gender: M F

Home Address: _____

Home Phone: _____ Work Phone: _____ Other: _____

Employer Name and Address: _____

Employer Phone: _____

MEDICAL INSURANCE INFORMATION

Primary Insurance Name: _____

Subscriber Name: _____ Relationship to Insured: _____

Subscriber # (Policy #): _____ Group #: _____

Insurance Address: _____

Secondary Insurance Name: _____

Subscriber Name: _____ Relationship to Insured: _____

Subscriber # (Policy #): _____ Group #: _____

Insurance Address: _____

PHARMACY

Primary Insurance Name: _____

Subscriber Name: _____ Relationship to Insured: _____

Subscriber # (Policy #): _____ Group #: _____

Insurance Address: _____

Secondary Insurance Name: _____

Subscriber Name: _____ Relationship to Insured: _____

Subscriber # (Policy #): _____ Group #: _____

Insurance Address: _____

DENTAL

Primary Insurance Name: _____

Subscriber Name: _____ Relationship to Insured: _____

Subscriber # (Policy #): _____ Group #: _____

Insurance Address: _____

Secondary Insurance Name: _____

Subscriber Name: _____ Relationship to Insured: _____

Subscriber # (Policy #): _____ Group #: _____

Insurance Address: _____

VISION

Primary Insurance Name: _____

Subscriber Name: _____ Relationship to Insured: _____

Subscriber # (Policy #): _____ Group #: _____

Insurance Address: _____

Secondary Insurance Name: _____

Subscriber Name: _____ Relationship to Insured: _____

Subscriber # (Policy #): _____ Group #: _____

Insurance Address: _____

I authorize the release of any medical information necessary for insurance/prescription certification or to process insurance claims. I agree to be solely responsible for any balances that my insurance does not pay. I understand this to include, but not limited to any charges deemed above “reasonable and customary” by said insurance company. I further understand that I am responsible for any collection and/or legal fees incurred as a result of non-payment on my account.

Patient Guardian/Guarantor Signature: _____ Date: _____