PRIVATE INSURANCE

AUTHORIZATION TO FURNISH INFORMATION AND ASSIGNMENT OF BENEFITS

The San Carlos Apache Healthcare Corporation may disclose all or part of the patient's medical record to any insurance company, worker's compensation carrier, or other party that may be liable for payment of medical expense incurred by patient.

I hereby assign to the SCAHC such insurance benefits that I may have, pertaining to payment for medical services and supplies furnished to me by the I.H.S I authorize payment of such benefits directly to SCAHC. I understand that this assignment will remain in effect, unless revoked by me in writing.

Primary Insured Name: _____ HR#_____
Insured's SS# _____ Insured DOB:_____
Place of Employment: _____ Employer PH#_____

PRIVATE INSURANCE INFORMATION

MEDICAL COVERAGE
Insurance Company Name: _____
Policy Number _____ Group#_____
Effective Date:_____ Termination Date: _____
Coverage Type: ( ) Family ( ) Single *Is Insurance Card Attached ( ) Yes ( ) No*

DENTAL COVERAGE
Insurance Company Name: _____
Policy Number _____ Group#_____
Effective Date:_____ Termination Date: _____
Coverage Type: (◯) Family (◯) Single *Is Insurance Card Attached (◯) Yes (◯) No*

PHARMACY COVERAGE
Insurance Company Name: _____
Policy Number _____ Group#_____
Effective Date:_____ Termination Date: _____
Coverage Type: (◯) Family (◯) Single *Is Insurance Card Attached (◯) Yes (◯) No*

VISION COVERAGE
Insurance Company Name: _____
Policy Number _____ Group#_____
Effective Date:_____ Termination Date: _____
Coverage Type: (◯) Family (◯) Single *Is Insurance Card Attached (◯) Yes (◯) No*

List everyone who is covered under this Insurance Plan

Last, First, Middle Name	DOB	Relationship	HR#

**Is anyone covered under this plan pregnant? ( ) Yes ( ) No

Patient Signature _____ Date _____ PBO Representative _____ Date _____

EFF2/2015