HEALTH INSURANCE INFORMATION FORM FOR EXPANDED MEDICAL SERVICES

Maranacook School-Based Health Center 2017-2018

Student Name: _____ Social Security Number: ____-__-____

Student's Date of Birth: _____ Gender (circle one): Male Female

Name of parent/guardian: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Health Insurance Company (e.g. Anthem, MaineCare, Aetna, etc.): _____

Health Insurance Company Address: _____

Plan Type (e.g. HMO, PPO, POS): _____

Does your plan have a high deductible that you need to meet before acute medical visits will be covered?
Yes ___ No ___ Not sure ___

Effective Date of Insurance (when did coverage begin?): _____

Subscriber's Name (whose policy is this?): _____

Subscriber's Date of Birth: _____ **Subscriber's Social Security Number:** ___-__-____

Health Insurance Policy Number: _____

Health Insurance Group Number: _____

Employer (e.g. Saunders Manufacturing, State of Maine, CMP, etc.): _____

Please complete these forms by **September 15, 2017** and return to:
School-Based Health Center in high school or **Wellness Center** in middle school

If you have any questions about these forms or about billing, please contact:
Health Center director at 685-4923 x1019