FERRIS STATE UNIVERSITY
BIRKAM HEALTH CENTER
HEALTH INSURANCE INFORMATION

Student Name:_____
Last First Middle
Student ID#:_____Date of Birth:_____

HEALTH INSURANCE COVERAGE: Please complete the sections below regarding your current health insurance coverage. Please attach a photocopy of the front and back of your health insurance card(s). You may also fax the information to (231)591-5970.

PRIMARY INSURANCE

Policy Holder (Subscriber) Information

Subscriber's Name:_____Date of Birth:_____
Relationship to Patient:_____
Subscriber's Address:_____

City: State: Zip Code:

Insurance Information

Insurance Company Name:_____
Policy/ID/Contract Number (include alpha characters):_____
Group Number:_____
Insurance Company Address (where claims should be mailed to):_____

City: State: Zip Code:
Insurance Company Phone Number:_____

SECONDARY INSURANCE

Policy Holder (Subscriber) Information

Subscriber's Name:_____Date of Birth:_____
Relationship to Patient:_____
Subscriber's Address:_____

City: State: Zip Code:

Insurance Information

Insurance Company Name:_____
Policy/ID/Contract Number (include alpha characters):_____
Group Number:_____
Insurance Company Address (where claims should be mailed to):_____

City: State: Zip Code:
Insurance Company Phone Number:_____