BILLING AND INSURANCE INFORMATION

Group Health Cooperative
of South Central Wisconsin

PATIENT INFORMATION

Last Name ________________________________ First Name ______________________________ MI ______ Sex ___________

GHC-SCW Member Number ___________________________________

Birthdate (MM/DD/YY) __________________________ Social Security Number __ __ __ - __ __ - __ __ __ __

Address _______________________________________ Apt. # _____ City ___________________ State _____ Zip. ___________

Home Phone Number _________________________ Cell Phone Number _________________________

PERSON RESPONSIBLE FOR BILL (Not required if same as above. Parent or guardian if patient is a minor)

Last Name ________________________________ First Name ______________________________ MI ______ Sex ___________

GHC-SCW Member Number ___________________________________

Birthdate (MM/DD/YY) __________________________ Social Security Number __ __ __ - __ __ - __ __ __ __

Address _______________________________________ Apt. # _____ City ___________________ State _____ Zip. ___________

Home Phone Number _________________________ Cell Phone Number _________________________

Relationship to Patient __________________________________

MEDICARE INFORMATION – If you are on Medicare, please complete the section below:

Medicare Number _____________________________________ Effective Date (MM/DD/YY) ______________________________

I have Medicare because (please check one): ☐ I am retired. ☐ I am disabled. ☐ I have end stage renal disease.

Do you have Medicare Supplemental Insurance? ☐ Yes ☐ No Are you employed? ☐ Yes ☐ No

IF YOU DO NOT HAVE HEALTH INSURANCE:

- You may be asked for a payment before receiving services.
- You will get a bill for the remaining balance.
- Payment is due within thirty (30) days of receiving your bill.

If you are not able to pay the bill, please call the GHC-SCW Medical Billing Department at (608) 251-4138 to talk about payment arrangements.

My signature below means that I officially agree with the following statements:

- I have read this form and I understand what it says.
- The information I wrote above is true, correct and complete.
- I give GHC-SCW permission to send a bill to my current health insurance company and any future health insurance company I work with; this bill will release health and insurance information about me or my child.
- I am responsible to pay for my health care even if my health insurance doesn't pay for all the services I receive. I agree to pay the balance.
- I voluntarily agree to receive treatment for myself or my child at GHC-SCW.
- I understand that I may ask for the GHC-SCW Notice of Privacy Practices.

Patient Signature ____ Date (MM/DD/YY) ________________

Parent/Guardian Signature (if the patient is a minor) _________________________________ Date (MM/DD/YY) ________________