**Student Health Services**
**The Ohio State University**
**1875 Millikin Road**
**Columbus, OH 43210**
**Phone: (614) 292-4321**
**Fax: (614) 688-8347**

Patient Name:

Date of Birth:

# INSURANCE REGISTRATION AND FINANCIAL UNDERSTANDING FORM

## Responsible Party: Primary Insurance

| Name of Policy Holder: | | Date of Birth: | |
|---|---|---|---|
| Policy Holder Address: | City: | State: | Zip Code: |
| Insurance Name: | Insurance ID#: | | |

## Responsible Party: Secondary Insurance

| Name of Policy Holder: | | Date of Birth: | |
|---|---|---|---|
| Policy Holder Address: | City: | State: | Zip Code: |
| Insurance Name: | Insurance ID#: | | |

## Pharmacy Insurance

| Rx ID#: | Rx BIN#: | Rx Group#: |
|---|---|---|

## Insurance Authorization and Financial Understanding

Student Life Student Health Services (SLSHS) is contracted with Aetna, Anthem Blue Cross & Blue Shield, Cigna, CareSource Medicaid of Ohio, Medical Mutual of Ohio, NGS/Prime Care, and United Healthcare.

SLSHS will submit a claim to your insurance carrier regardless of their contract status. SLSHS will accept the terms of your insurance plan as indicated on the Explanation of Benefits. You will be financially responsible for any unpaid balance including but not limited to deductibles, coinsurance, and/or non-covered services.

In the event of an overpayment on your account, a refund will be issued by the University Bursar's Office. However, these funds may be applied to any outstanding balance at the University.

Insurance information must be provided within 30 days from the date of service. If the information is not provided within this timeframe, the patient could be liable for the charges incurred.

I authorize release of my health record to my insurance or any other insurance carrier for claims processing.
I understand and have completed the Insurance Registration and Financial Understanding form.
I have received and understand the Insurance Contract Status notice.
I understand SLSHS is NOT a Medicare, Medicaid or Medicaid expansion plan provider, with the exception of CareSource Medicaid of Ohio.
I am responsible for any unpaid balance.
I understand if I fail to provide my insurance information within 30 days from the date of service, I may be liable for the charges incurred.

Patient Signature: Date:



For Office Use Only
Date:_____ By:____ AV