1200 OAKLEAF WAY STE A
ALTOONA WI 54720
TEL 715.832.1400

757 LAKELAND DR. STE B
CHIPPEWA FALLS WI 54729
TEL 715.723.8514

Health Insurance Information Form

Primary Insurance Information:

Insurance company____________________________________

Member ID #_______________________________ Group #________________

Insurance company phone number_____________________________

Employer (if HEOS or Multiplan listed on card) _____________________________________

Name of Policy Holder______________________________ Policy Holder's DOB_____________

Policy holder's relationship to Patient______________________

Social Security# of Policy Holder (if insurance is Tricare) __________________________

Secondary Insurance Information:

Insurance company____________________________________

Member ID #_______________________________ Group #________________

Insurance company phone number______________________________

Employer (if HEOS or Multiplan listed on card) _____________________________________

Name of Policy Holder______________________________ Policy Holder's DOB_____________

Policy holder's relationship to Patient______________________

Social Security# of Policy Holder (if insurance is Tricare) __________________________

Please note that we are unable to bill without accurate Health Insurance information. All charges incurred will be patient responsibility until this information is received. Please send along a copy of the insurance card(s) if possible. Thank you!

Billing Department