GILLETTE REPRODUCTIVE HEALTH

P O Box 2915
1304 W. 4th Street
Gillette, WY 82716
(307) 682-8110 fax (307) 685-1193

INSURANCE INFORMATION

Primary Insurance

Primary Insurance_____ Phone # of Insurance_____

Address of Insurance_____ City_____ State_____ Zip_____

ID#_____ Group#_____

Policy Holders Name_____ Relationship to Policy Holder_____

Policy Holders Address_____

Policy Holders Birth Date_____ Policy Holder Phone Number _____

Policy Holders SSN_____ Policy Holders Place of Employment_____

Secondary Insurance

Secondary Insurance_____ Phone # of Insurance_____

Address of Insurance_____ Phone # of Insurance_____

Policy Holders Name_____ Relationship to Policy Holder_____

Policy Holders Address_____ Policy Holders Birth Date_____

ID#_____ Group#_____ Policy Holders SSN_____

Policy Holders Place of Employment_____

Insurance Assignment:

I, the undersigned, authorize the above named provider to disclose medical or other information required to processing claims. I understand that third party payers will be billed full price for services reviewed. If charges are denied a adjustment will be made according to my fee scale, with the balance being my financial responsibility. I authorize payment of services to be made to Health Services of Campbell County.

Client Signature:_____ Date_____

Staff Signature:_____ Date_____