LAFAYETTE COLLEGE

INSURANCE INFORMATION

(1) Student is enrolled in the Lafayette College Student Health Insurance program underwritten by University Health Plans. YES ☐ NO ☐

If the answer to Question 1 is YES, YOU DO NOT NEED TO complete the information in the boxes. Move directly to the bottom of the form, provide copies of your insurance card and sign below.

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(2) Student is covered under another health insurance plan that I have verified to be equivalent to the University Health Plan. YES ☐ NO ☐

If the answer to Question 2 is YES, PLEASE COMPLETE ALL SECTIONS below.

Student's Name : ________________________ **Campus Box No. :** _______ **Date of Birth :** ____/____/_____

L# or Social Security Number :________________________**Cell Number : (** **)** _______-__________

Subscriber's Name : ________________________________ **Date of Birth :** ____/____/_____

Address : ______________________ **City :** ______________**State :** _____ **Zip :** __________

Relationship to student : ***circle one*** **Self** **Parent** **Guardian** **Other** ____________________

Subscriber's Employer : ____

INSURANCE INFORMATION

Name of Insurance Company : ____

Insurance Company Billing Address : ____

City : ______________________ **State :** _______ **Zip:** _____________

Telephone Number : (**)** ______________________________

Insurance ID number : ________________________ **Group number :** ________________________

Does your insurance cover out of area non-emergent care? **YES** ☐ **NO** ☐

Does your insurance require a guest provider? **YES** ☐ **NO** ☐

Do you need a referral from your primary care physician for outpatient services? **YES** ☐ **NO** ☐

Please CIRCLE those services that require a referral or authorization to obtain insurance coverage :

CT Scan ***MRI*** ***Bone Scan*** ***Ultrasound*** ***Xray*** ***Other*** ____________________

Please circle the Lab in your network? **QUEST** **LABCORP**

PLEASE PLACE COPIES OF THE FRONT AND BACK OF YOUR INSURANCE CARD BELOW.

FRONT OF INSURANCE CARD	BACK OF INSURANCE CARD

By signing below, I give permission to be treated at the Student Health Center and for Bailey Health Center to release information necessary to process insurance claims.

Student Signature____