Advocate Health Care

Family Care Network
Business Office
P.O. Box 776
Oak Lawn, IL 60454-0776

Primary Health Insurance Information

(Incomplete Information Will Cause Payment Delays)

PATIENT INFORMATION

Name_______________________________S.S. #_______________________

Address_______________________________Phone #_______________________

City_______________________State__________Zip Code_______________________

Gender ____________ Birth Date__________________Child____Single____Married____Widowed____Separated____Divorced____

Employed by _______________________________Work Phone #_______________________

PRIMARY HEALTH INSURANCE COMPANY

Insurance Company_______________________________Phone #_______________________

Group/Policy #__________________Ins. Co. I.D. #__________________ Policy Effective Date________________

Name of Policyholder_______________________________S.S.#_______________________

Sex ___M ____F Age________ Birth Date__________________Single____Married____Widowed____Separated____Divorced____

Policyholder's Relationship to Patient:__________________ Phone #_______________________

Policyholder's Home Address *(if different from patient)*_______________________________

City_______________________State__________Zip Code_______________________

Policyholder's Employer_______________________________ Work Phone #_______________________

HMO PLANS

Primary Care Physician Name_______________________________

Primary Care Physician Hospital Affiliation_______________________________

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical or other information necessary to process claims for services rendered by *Advocate Family Care Network.* I also authorize payment of medical benefits directly to *Advocate Family Care Network*.
I understand that I am personally responsible for that portion of the fee, which my insurance company does not pay, for example, yearly deductibles and patient co-payments.

I will assume complete responsibility for all fees incurred,
in the event my insurance company does not cover this charge.

_______________________________ _______________________________
Signature Of Patient (12 Yrs. & Older) Date

_______________________________ _______________________________
Print Name of Responsible Party Signature of Responsible Party