IOWA STATE UNIVERSITY
Thielen Student Health Center

2647 Union Drive
Ames, Iowa 50011
Phone: 515-294-5801
Fax: 515-294-5457

Medical Insurance Information

SUBMIT INSURANCE THREE WAYS:

1. *Scan and email to: submitinsurance@iastate.edu*
2. *Drop off at the Student Health Center, corner of Union drive and Sheldon Avenue*
3. *Mail to: Student Health, ATTN: Insurance Information, Thielen Student Health Center, 2647 Union Drive, Ames, Iowa 50011-2029*

Patient Information:

Patient Full Name:		
University ID#:	Date of Birth (MM/DD/YYYY):	Age:
Phone #:	Email Address:	

Eligibility Status: ☐ Undergraduate ☐ Graduate Assistant ☐ Post Doctorate ☐ Spouse ☐ Dependent

Student Status: ☐ Full-time ☐ Part-time (*Number of credits:* _____)

☐ I am **NOT** covered by any insurance polices. _____

STOP and SIGN statement - DO NOT complete rest of form. *Patient's Signature and Date*

☐ I have the following types of insurance: (*check all that apply*) ☐ **MEDICAL** ☐ **PHARMACY**

If the patient is covered under **more than one plan**, please **list the primary insurance** in the space provided below. **Provide any secondary insurance information** - such as the policy holder information for this secondary plan on the back of this form.

PLEASE ATTACH A COPY OF ALL ACTIVE INSURANCE CARDS (FRONT AND BACK).

Medical Insurance Information: (ALL INFORMATION BELOW IS REQUIRED)

Primary Policyholder's Full Name:		
Relationship to Patient:		
Phone Number:	Date of Birth (MM/DD/YYYY):	
Address:		
City:	State:	Zip:

Complete only if information is not located on copy of insurance card:

Insurance Company:	Phone Number:	
Address:		
City:	State:	Zip:
Policy Number:	Group Number:	

Complete only if this is a new policy:

Does this policy replace last year's policy? ☐ No ☐ Yes If yes, end date: _____

Name of previous insurance company: _____

On my behalf (or for my underage child), I authorize the release of any medical information necessary to process claims submitted to the insurance companies I have provided to the Thielen Student Health Center. I also authorize payment of benefits to the clinic/physician or supplier of services rendered indicated on the billing document.

Patient's Printed Name

Today's Date (MM/DD/YYYY)

Signature of Patient (or Legal Representative, if applicable)

If applicable, Legal Representative's Printed Name and Relation to Patient (e.g., Mother, Father, Guardian, etc.) or signature of witness (witness not required in Iowa, but may be in other states).