



INSURANCE INFORMATION FORM

(Use the Healthy Option Student Insurance Information Form for Aetna Student Insurance)

Please Print Clearly and Complete All Information

Last Name	First	Middle Initial	NU student ID # OR Social Security #
Local Address/ City / State/ Zip			
Date of Birth	Telephone (Local/Cell)	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	

Student ___ UNL ___ UNO ___ UNMC ___ UNK ___ Other University Employee Community

INSURANCE COMPANY The University Health Center is a Blue Cross Blue Shield of Nebraska preferred provider. Please check with your insurance carrier out-of-network coverage.

Patient Initials

Insurance Company Name _____

Address _____ City/State/Zip _____

INSURANCE POLICYHOLDER INFORMATION: Parent/Guardian Spouse Self

Last Name	First Name	Middle Initial	Suffix <input type="checkbox"/> Jr <input type="checkbox"/> Sr <input type="checkbox"/> Other _____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address _____		City _____		
State _____		Zip _____		Country _____
Date of Birth _____		Policyholder Telephone (_____) _____		
Policy ID # _____		Group/Plan # _____		

EMERGENCY CONTACT:

Name _____ Phone# (_____) _____ Relationship _____

Address _____ City/State/Zip _____

ANNUAL AUTHORIZATION

I consent to the use or disclosure of my protected health information by the University Health Center (UHC) for the purpose of analyzing, diagnosing, and providing treatment to me, obtaining payment for health care services rendered or to be rendered, or to conduct health care operations. A copy of this consent is as valid as the original.

I authorize my insurance benefits to be paid directly to the University Health Center (UHC). I assume full responsibility for and agree to pay for all services rendered or to be rendered. I understand I have a right to receive a copy of this consent upon request, and to revoke this consent in writing at any time except to the extent that UHC has taken action in reliance on this consent.

This authorization is valid one year from the date signed or through the term of coverage of the policy, and during the required period to process the claims.

Patient/Parent/Guardian Signature _____ Date _____