# INSURANCE INFORMATION

*(Parents/Guardians: Please provide this information unless you are purchasing insurance through St. Andrew's.)*

**STUDENT NAME:** ______________________________

**PRIMARY HEALTH INSURANCE COVERAGE:** ***Must include an ENLARGED copy of the FRONT & BACK of insurance card.***

INSURANCE COMPANY ______________________________

NAME OF POLICY HOLDER ______________________ BIRTHDATE OF POLICY HOLDER ______________

GUARANTOR (name of Parent/Guardian responsible for payment) ______________________________

GROUP#/NAME ______________________________

ID#/POLICY# ______________________ SS# OF POLICY HOLDER __ __ __ - __ __ - __ __ __ __

INSURANCE CO. ADDRESS ______________________________

INSURANCE CO. PHONE ______________________________

IS THIS INSURANCE PLAN A: ☐ PPO ☐ HMO ☐ MEDICAID ☐ OTHER ______________

ARE REFERRALS REQUIRED? (Please check with your insurance company.) YES ☐ NO ☐

OUT-OF-NETWORK COVERAGE OR AWAY FROM HOME COVERAGE? YES ☐ NO ☐ *(please check with your insurance company)*

DOES YOUR POLICY INCLUDE PRESCRIPTION COVERAGE? YES ☐ NO ☐ COPAY? ______________
*(Must include an ENLARGED copy of the FRONT AND BACK of prescription drug card)*

PRESCRIPTION ID/ACCOUNT #: ____________ Rx BIN # ________ PCN # ________ GRP# ________

COMPANY THAT ADMINISTERS PRESCRIPTION COVERAGE: ______________ PHONE: ______________

**Please provide an ENLARGED copy of the FRONT and BACK of ALL insurance cards (health, dental and prescription) for the student.**

**An enlarged copy of these cards is REQUIRED.**

**Thank you!**

**DENTAL INSURANCE COVERAGE:** ***Must include an ENLARGED copy of the FRONT & BACK of insurance card.***

INSURANCE COMPANY ______________________________

POLICY# ______________ GROUP# ______________ ID# ______________

INSURANCE CO. ADDRESS ______________________________

INSURANCE CO. PHONE ______________________________

# CARE PROVIDER INFORMATION *(Parents/Guardians: Please provide this information.)*

**HEALTH CARE PROVIDER:**

PHYSICIAN ______________________________

PHYSICIAN'S FULL ADDRESS ______________________________

PHYSICIAN'S OFFICE PHONE ______________________ FAX (if available) ______________

**DENTAL CARE PROVIDER:**

DENTIST ______________________________

DENTIST'S FULL ADDRESS ______________________________

DENTIST'S OFFICE PHONE ______________________ FAX (if available) ______________