Flathead City-County Health Department
Community Health Nursing Services and Immunization Clinic
Insurance Information Form

Patient Name (Please Print):_____DOB:_____/_____/_____

INSURANCE INFO (Primary): Please provide front and back copy of insurance card

☐ HMK+/Medicaid ☐ HMK (CHIP) ☐ Medicare (65+/Disabled) ☐ Other:_____

Subscriber Id #_____Group #_____Group Name_____

Primary Insured Person's Name (Please Print):_____

DOB:_____/_____/_____ SSN:_____-_____-_____ Phone #: (_____)_____-_____

Mailing Address:_____City:_____State:_____Zip:_____

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Other:_____

INSURANCE INFO (Secondary): Please provide front and back copy of insurance card

☐ HMK+/Medicaid ☐ HMK (CHIP) ☐ Medicare (65+/Disabled) ☐ Other:_____

Subscriber Id #_____Group #_____Group Name_____

Primary Insured Person's Name (Please Print):_____

DOB:_____/_____/_____ SSN:_____-_____-_____ Phone #: (_____)_____-_____

Mailing Address:_____City:_____State:_____Zip:_____

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Other:_____

INSURANCE INFO (Tertiary): Please provide front and back copy of insurance card

☐ HMK+/Medicaid ☐ HMK (CHIP) ☐ Medicare (65+/Disabled) ☐ Other:_____

Subscriber Id #_____Group #_____Group Name_____

Primary Insured Person's Name (Please Print):_____

DOB:_____/_____/_____ SSN:_____-_____-_____ Phone #: (_____)_____-_____

Mailing Address:_____City:_____State:_____Zip:_____

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Other:_____

School Child Attends:_____ Grade:_____

Fax to: 751-8127 ATTN: Elizabeth

Or

Deliver to: Flathead City-County Health Department (First floor)