# Insurance Information

We are a health care facility and we depend upon our ability to collect payment from your insurance carrier in order to maintain the current hours of the wellness center. Please complete only the section that applies to your child. If your child does not have insurance, check the box below. *Please include a copy of your insurance card front & back.*

## Child's Information

Child's Legal Name:_____ Date:_____

Phone number:_____ Birth Date:_____ SSN:_____

Address:_____

Covered by an insurance plan? Yes__ No*__ If Yes, please fill in the appropriate section below.

## Private Insurance Information

**Insured Parent/Legal Guardian**: _____

**Insured's Birth Date**: _____ **Insured's SSN**: _____

Address (if different from child): _____

Place of Employment: _____

Insurance Company and Complete Address: _____

_____

Insurance Company Phone Number: _____

Group Number: _____ ID Number: _____

From (month/year): _____ to (month/year): _____

## Medicaid Information

Please circle your Medicaid carrier

**Unicare** **Carelink**

Medicaid ID #: _____ Member ID# :**(Carelink)**_____

PCP/HMO Provider: _____ Provider Phone: _____

## Children's Health Insurance Program (CHIP)

Name listed on card: _____

ID# on card: __ __ __ __ __ __ __ __ __ __ Group#: 7771

From (month/year):_____ to (month/year): _____

***Number of people in household: _____ Gross Monthly Income: $_____**

**Does your child qualify for free or reduce lunch? Yes ___ No___**

*Revised June 22, 2007*