MERCER Medicine

IN ORDER TO EXPEDITE YOUR VACCINE ADMINISTRATION PROCESS, SEND THIS COMPLETED FORM WITH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD TO CHFORMS@MERCER.EDU ASAP PRIOR TO YOUR VISIT

PERSONAL INFORMATION

(please print all information clearly)

PATIENT NAME (PRINTED): ______________________________

DATE OF BIRTH: ____________ **AGE:** ________ **SEX: MALE** ________ **FEMALE** ________

MERCER ID #: ____________________ **(EMPLOYEES / STUDENTS)**

PHONE: ____________________ **EMAIL ADDRESS:** ____________________

HOME STREET ADDRESS: ______________________________

CITY: ____________________ **STATE:** ________ **ZIP:** ________

PLEASE CHECK APPROPRIATE BOX: EMPLOYEE (FACULTY/STAFF) ☐ **STUDENT** ☐ **OTHER** ☐

INSURANCE INFORMATION

(PLEASE ENTER ALL REQUESTED INFORMATION IN THE BLANKS AND PROVIDE A COPY OF THE FRONT & BACK OF INSURANCE CARD)

(IF YOU ARE ON YOUR PARENT/SPOUSE INSURANCE PLAN, PLEASE ENTER THEIR NAME & DOB IN THE MEMBER SECTION)

PRIMARY INSURANCE: ______________________________

MEMBER NAME : ____________________ **MEMBER DOB:** ____________________

MEMBER NUMBER: ____________________ **GROUP NUMBER:** ____________________

SECONDARY INSURANCE: ______________________________

MEMBER NAME : ____________________ **MEMBER DOB:** ____________________

MEMBER NUMBER: ____________________ **GROUP NUMBER:** ____________________

I AUTHORIZE MERCER MEDICINE TO VERIFY MY INSURANCE BENEFITS AND SUBMIT MY CLAIM TO MY INSURANCE CARRIER.

______________________________ ____________________

SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE **DATE**