



Capitol Region Education Council

INSURANCE INFORMATION FORM

Child's Name		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth	Child's Social Security Number	Home Phone
School: Grade: _____	Primary Care Physician:	Date

PRIMARY INSURANCE INFORMATION AND PERMISSION

***Please check the box that applies**

<input type="checkbox"/> Blue Care Family Plan (Husky)	<input type="checkbox"/> Community Health Network (Husky)	<input type="checkbox"/> HealthNet (Husky)
<input type="checkbox"/> Preferred One (Husky)	<input type="checkbox"/> Blue Cross Blue Shield (Commercial)	<input type="checkbox"/> United Health Network
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Other (please list) _____	

Please Print

Policy Holder (parent or guardian):	Name	DOB:	SSN:
Home Address:	Address	City	State ZIP
Policy Holder Phone Numbers:	Home Phone	Work Phone	Cell Phone
Relationship to Child:	Please check one: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other (specify) _____		
Employer's Name & Address:	Name		
	Address	City	State ZIP
Child's Address (if different from Policy Holder):	Address	City	State ZIP
Insurance Company Claim Address:	Address	City	State ZIP
Insurance Company Phone Number:	Phone#		
Child's Insurance ID Number:	ID#		
Insurance Group Number:	Group#		
Child's Medicaid Number (if applicable):	Medicaid#		

PERMISSION AND RELEASE OF INFORMATION: I authorize the release of any medical or other information required to process claims. CREC has my permission to receive reimbursement for claims submitted to my insurance carrier or Federal Health Care Financing Administration on behalf of my eligible child who is named at the top of this form.

Parent/Guardian Signature	Date
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Capitol Region Education Council is committed to protecting the privacy and confidentiality of all Protected Health Information of our students.

Rev. 3/31/05 kr