**Marion County Public Health Clinic**

☐ HIV ☐ RH ☐ STI ☐ TB ☐ IMMS – Alert IIS#: _____

*If Regence/Kaiser Ins. refer to their PCP*

Date: _____

RT ID#: _____

## Private Insurance Information

*Attach copy of insurance card if available (front and back)*

Client's Name _____ Date of Birth _____

Insurance Name _____ Phone # _____

Policy # _____ Group # _____

Subscriber Name _____ Phone # _____

Subscriber's Date of Birth _____

*Assignment of Benefits*

By providing insurance information and a copy of my insurance card, I hereby authorize Marion County Public Health Clinic to bill my health insurance for services rendered and to receive payment directly of the benefits otherwise payable to me. I understand that the benefit contract is between me and the health plan. Therefore, any coinsurance, deductible, or services denied will be due by me and I may be billed. I consent the release of any medical or other information necessary to process payment for these services.

_____ _____

*Client's Signature* *Date*

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**OFFICE STAFF USE ONLY**

| Code | Vaccines Needed | Cost | Code | Vaccines Recommended | Cost |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
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| | | | | | |
| | | | | | |

Reason for Vaccines: _____ Staff Name: _____

**BILLING STAFF USE ONLY**

| | |
|---|---|
| **RH/STI Clinic does insurance cover?**<br>Office visits: ☐ Yes ☐ No<br>Birth Control: ☐ Yes ☐ No<br>Labs: ☐ Yes ☐ No | **Notes:** |
| **In Network Benefits** | **OON Benefits** |
| **Deductible Met:** | **Deductible Met:** |
| **Notes:** | ***Notes from Supervisor:*** |

*Billing Staff Name* _____ *Date* _____