AUTHORIZATION TO BILL INSURANCE 2021

THE UNIVERSITY OF ARIZONA
CAMPUS HEALTH
Counseling & Psych Services

Legal Name: _____ Preferred Name: _____
Last *First* *Middle Initial*

Pronouns: _____ Date of Birth: _____ Sex at Birth: ☐ Female ☐ Male ☐ Other

Gender Identity: ☐ Female ☐ Transgender ☐ Different Identity: _____
☐ Male ☐ Transfemale ☐ Gender Nonconforming
☐ Transmale

Local Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number to leave a Secure Message: _____ Mobile Carrier: _____
UA Status: ☐ Enrolled Student ☐ Post-Doctoral Fellow ☐ J1 Student Intern

I have one of the following insurances and <u>want the Campus Health Service (CHS)/Counseling & Psych Services (CAPS) to bill my insurance</u> for all billable services *(Check one):*

☐ Aetna Student Health Insurance Plan
☐ Aetna Commercial
☐ Blue Cross Blue Shield
☐ Campus Health Supplement (Campus Care)
☐ Health Net
☐ United Health Care (Optum)
☐ I do not have any insurance and will be paying fee-for-service
☐ I have been advised and I understand Campus Health Service cannot bill my insurance and I will pay fee-for-service
☐ Athletics Department Referral
☐ None of these

CAPS does NOT bill any other third party insurance. If you have other insurance, please ask for an itemized statement when checking out.

Main Policy Holder's Information

Policyholder's Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Sex: _____ Date of Birth: _____
Policyholder's Employer Name: _____
Member ID#: _____ Group #: _____

I understand that if the above Policyholder Information is missing or incorrect, I will be financially responsible for visit charges. _____
Initials

If applicable, Secondary Insurance: _____ Member ID: _____

If applicable, check the box below for today's visit:

☐ **<u>I DO NOT WANT</u>** CAPS to bill my insurance for today's visit(s) Initials: _____

- I understand that by checking an insurance box on this form that I want my insurance billed for all billable services. I will be responsible for notifying the CHS in writing <u>prior to</u> any given appointment if I do not want my insurance billed and I want to pay fee-for-service for that specific appointment.
- I understand that if I have not met my insurance policy deductible, my out-of-pocket costs for CHS services may be higher than the regular (uninsured) fees-for-service.
- If the above insurance information should change I am responsible to advise CHS of the change.
- I understand CHS does not file with non-contracted insurance carriers and I can ask for an itemized statement when I check out.
- I understand that charges denied by my insurance company will be my responsibility and that I will be billed at commercial rates. This includes if I have an insurance deductible which has not been met.
- I understand that I am responsible for charges incurred for services rendered at CHS/CAPS.
- I understand that after any visit charge, I may accrue additional charges for pharmacy, laboratory tests, or a daily user fee.
- I understand that labs drawn at CHS are sent to Sonora Quest Laboratories. Not all insurance companies are contracted with Sonora Quest. I may accrue additional charges for labs or I may need to go to an outside laboratory that is participating under my insurance plan.
- I authorize CHS to release any information required to process my insurance claims.
- I authorize payment of medical benefits directly to CHS.

_____
Signature (signed electronically) Date

CAPS F-GENADM 1.7.21

COUNSELING & PSYCH SERVICES
The University of Arizona / Campus Health Service
www.health.arizona.edu

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Phone: 520-626-3100 FAX: 520-626-2394