REGISTRATION FORM

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

Preferred Name: **UA ID#**

Preferred Pronouns:

Date of Birth: **Sex at Birth:** ☐ **Female** ☐ **Male** ☐ **Other**

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

Local Address :

City: **State:** **Zip Code:**

Phone Number to leave a Secure Message: ( ) **Mobile Carrier:**

UA Status: ☐ **Enrolled Student** ☐ **CESL** ☐ **Employee** ☐ **Visiting Scholar/Post-Doctoral Fellow/J1Student Intern**

(If applicable, please check ALL that apply)

☐ **CampusCare (Health Care Option)** ☐ **Aetna Student Health Insurance Plan**

☐ **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** ***(insurance information required)***

I have one of the following insurances and want the CHS to bill my insurance for all billable services.

☐ **Aetna** ☐ **Blue Cross/Blue Shield** ☐ **Cigna** ☐ **United HealthCare** ☐ **CESL Aetna Student Health**

The Campus Health Service (CHS) is a participating provider to most Aetna, United HealthCare, Cigna and Blue Cross/Blue Shield plans for Primary Care Services. NOTE: HMO plans may require an "Away-from-Home" plan or designation of CHS as your Primary Care Provider.

Main Policyholder's Information:

Name: ***Relationship:***

Address:

City: ***State:*** ***Zip Code:***

Phone: ( ) ***Sex:*** ***Date of Birth:***

Member I.D. ***Group Number:***

Employer:

If Applicable: Secondary Insurance: _____ Member ID: _____

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

☐ ***I understand that by checking the above insurance box that I want my insurance billed for all billable services. I will be responsible for notifying the CHS in writing prior to any given appointment if I do not want my insurance billed and I want to pay fee-for-service for that specific appointment. Initials***_____

☐ ***If the above insurance information should change I am responsible to advise CHS of the change. Initials***_____

- 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 had not been met.
- I understand that I am responsible for charges incurred for services rendered at CHS.
- I understand that after any visit charge, I may accrue additional charges for pharmacy, laboratory tests, x-rays, medical procedures/supplies, or a daily user fee. Charges for medical supplies may be billed by Hanger. Not all insurances companies are contracted with Hanger. I may accrue additional charges and will be billed directly by Hanger.
- 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 Date