HealthEast Medical Laboratory

INSURANCE INFORMATION FORM

Fax: (651) 232-3990 | EMAIL: hmlsnf@healtheast.org

♦ Please complete and fax this information within 24 hours of admission or changes♦

Facility Name _____ Today's Date: __ __ / __ __ / __ __

(Please check appropriate box) **❒ New Resident** **❒ Change in Billing Information**

Resident Name _____

Birthdate (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___ Sex:*(check one)* ☐ M ☐ F

Physician/Provider: _____

Patient Address (if different from facility): _____

Street _____

City _____ State _____ Zip _____

Insurance

Medicare Number (Cost Plan Medicare): _____

Medical Assistance or Medicaid Number:_____

Medica Number: _____

HealthPartners Plan Number: _____

Other Insurance Company _____

Phone Number:_____

Group ID:_____

Insurance Policy #: _____

Insurance Address:_____

Is the resident's Medicare Insurance primary or secondary? **(Check appropriate box)**

❒ Primary ❒ Secondary ❒ Does not apply

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HealthEast®