INSURANCE VERIFICATION FORM

Date:_____

UA Affiliation: (circle) Student CESL Employee Visiting Scholar/Post-Doctoral Fellow

Name:_____
Last First Middle Initial

UA ID#:_____ Birth Date:_____Phone #:_____

Address:_____

City:_____ State:_____Zip Code:_____

*The Campus Health Service (CHS) is a participating provider to **most** United HealthCare, Aetna, 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. We **DO NOT FILE** with non-contracted insurance carriers; please ask for an itemized statement when checking out.*

Main Policyholder's Information

In order for the CHS to file a claim, please complete to its entirety. If enrolled in CampusCare, services rendered at the CHS will first be billed under CampusCare, and then your insurance carrier for charges not covered.

Primary Insurance:

Name:_____
Last First Middle Initial

Birth Date:_____ Gender:_____ Phone #:_____

Address:_____

City:_____ State:_____Zip Code:_____

Insurance Carrier:_____

Member ID #:_____Group #:_____

Relationship to UA Affiliate:_____

Secondary Insurance:

Name:_____
Last First Middle Initial

Birth Date:_____ Gender:_____ Phone #:_____

Address:_____

City:_____ State:_____Zip Code:_____

Insurance Carrier:_____

Member ID #:_____Group #:_____

Relationship to UA Affiliate:_____

Submit completed form to:

UA Campus Health Service
Billing & Claims
1224 E. Lowell Street
Tucson, AZ 85721-0095

Fax: 520-626-9944