CHCA

PRIMARY CARE
PHYSICIAN (PCP)_____ _____ PHONE ( ) _____
LAST FIRST MIDDLE CITY STATE

REFERRING PHYSICIAN _____ _____ PHONE ( ) _____
IF DIFFERENT LAST FIRST MIDDLE CITY STATE

PATIENT NAME _____ HOME PHONE ( )_____
LAST FIRST MIDDLE

HOME ADDRESS _____
STREET TOWN/CITY STATE ZIP CODE

SOCIAL SECURITY # _____ DATE OF BIRTH _____ SEX M / F

EMPLOYER NAME _____ EMPLOYER PHONE ( ) _____EXT _____

EMPLOYER ADDRESS _____
STREET TOWN/CITY STATE ZIP CODE

GUARANT0R COMPLETE IF DIFFERENT FROM PATIENT DOB FOR GUARANTOR _____/_____/_____

PATIENT RELATION TO GUARANTOR: SELF _____ SPOUSE _____ DEP CHILD _____OTHER _____

NAME _____ SS# _____

ADDRESS _____ PHONE # ( ) _____
STREET CITY/STATE ZIP CODE

PRIMARY INSURANCE INFORMATION	SECONDARY INSURANCE INFORMATION
INSURANCE NAME _____	INSURANCE NAME _____
ADDRESS _____	ADDRESS _____
INSURANCE PHONE # ( )_____	INSURANCE PHONE # ( ) _____
SUBSCRIBER NAME _____	SUBSCRIBER NAME _____
PATIENT RELATIONSHIP TO SUBSCRIBER SELF ____ SPOUSE ____ DEP CHILD _____OTHER _____	PATIENT RELATIONSHIP TO SUBSCRIBER SELF ____ SPOUSE ____ DEP CHILD _____ OTHER _____
SUBSCRIBER ID#_____	SUBSCRIBER ID# _____
SUBSCRIBER SS# _____ DOB _____/_____/_____	SUBSCRIBER SS# _____DOB ____/____/_____

I HEREBY AUTHORIZE INSURANCE PAYMENT DIRECTLY TO CONNECTICUT HEALTH CARE ASSOCIATES AS APPLICABLE UNDER MY ACCOUNT NUMBER OTHERWISE PAYABLE TO ME AND AUTHORIZE CHCA TO RELASE MEDICAL INFORMATION TO INSURER AS NEEDED TO PROCESS CLAIMS ON MY BEHALF.

SIGNATURE _____ **DATE** _____