



**5. INSURANCE COVERAGE INFORMATION**

Name of Primary Insurance Company: \_\_\_\_\_

Address of Insurance Company: \_\_\_\_\_

Phone Number for Benefits: \_\_\_\_\_

Phone Number for Pre-Certification: \_\_\_\_\_

Employer's Name (Group): \_\_\_\_\_

Address: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Policy/Certificate/Identification Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Effective Date or Eligibility Date: \_\_\_\_\_

Name of Secondary Insurance Company: \_\_\_\_\_

Address of Insurance Company: \_\_\_\_\_

Phone Number for Benefits: \_\_\_\_\_

Phone Number for Pre-Certification: \_\_\_\_\_

Employer's Name (Group): \_\_\_\_\_

Address: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Policy/Certificate/Identification Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Effective Date of Eligibility Date: \_\_\_\_\_

**6. MEDICARE AND/OR MEDICAID PATIENTS ONLY**

Have you been admitted to any other hospital or Nursing Home within the last 60 days? NO \_\_\_\_\_ YES \_\_\_\_\_ If Yes:

Date of Admission: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_ Name of Facility: \_\_\_\_\_

Medicare Claim Number: \_\_\_\_\_ Medicare Recipient Number: \_\_\_\_\_

Part A Effective Date: \_\_\_\_\_ Part B Effective Date: \_\_\_\_\_ Medicaid Effective Date: \_\_\_\_\_

**7. NEWBORN PHYSICIAN INFORMATION**

**YOU MUST CHOOSE A DOCTOR FOR YOUR BABY BEFORE HOSPITAL ADMISSION.**

It is very important to make sure your pediatrician/family practice physician is a member of a medical plan that allows him or her to practice at Metropolitan Methodist Hospital. To find out if your baby's doctor is part of a health plan that offers Metropolitan Methodist Hospital as a choice, call your doctor's office.

Please contact your medical plan to make sure your pediatrician or family practice physician is currently a member of your medical plan.

Please contact your selected pediatrician/family practice physician before your hospital admission to make sure that he or she is currently accepting new patients.

Please notify Metropolitan Methodist Hospital with the name of the pediatrician or family practice physician you have selected.

Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date you notified your selected physician: \_\_\_\_/\_\_\_\_/\_\_\_\_

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**Please notify your insurance company for pre-certification requirements. Failure to Pre-Certify may result in a payment reduction penalty. Please notify your insurance company or your impending admission.**

**WHEN COMPLETED, PLEASE MAIL OR FAX THIS DATA SHEET BACK AS SOON AS POSSIBLE. OUR FAX NUMBER IS (210) 581-4906. FOR QUESTIONS, OUR PHONE NUMBER IS (210) 208-2200. WE'RE HERE TO HELP YOU FIND THE ANSWERS YOU NEED. THANK YOU.**