HP TEMPLATE

Health Plan/Payer Name

Identification Code:

Member Information

Member Name Last, First, MI:

Date of Service:

Member ID #:

Address:

Social Security #:

City:

State:

Zip:

Date of Birth:

Home Phone:

Sex:

Subscriber Information

Subscriber Name Last, First, MI:

Subscriber ID#:

Individual Relationship Code:

Provider Information

Provider Name:

Provider Eff Dt:

Provider Code ID

Provider Term Dt:

Contract Information

EmployerGroup Number:

Employer Name:

Benefit Code:

MedicalGroup/IPA Name:

Benefit Code Eff Dt:

MedicalGroup/IPA Number:

Benefit Code Term Dt:

Medical Group/IPA Effective Date:

Office Copay:

Medical Group/IPA Term Date: