OU STUDENT HEALTH SERVICE
INSURANCE INFORMATION REQUEST FORM

Patient Name: ______________________________ **PID#:** ________________________

Name of Insurance Company: ______________________________

Insurance Mailing Address: ______________________________
(ADDRESS TO SUBMIT CLAIMS TO)

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Insurance Company Telephone: ____________________

Policyholder's Name: ____________________ **Relationship to patient:** __________________

Policyholder's SS#: ______________________ **Date of Birth:** __________

Policyholder's Address: ____________________ **Policyholder's Telephone:** __________________

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Policyholder's ID# ________________________

Group# or Plan: ________________________ **Policyholder's Employer** ____________________

Please return this form to Student Health Service Room 113 within 24 hours so we can correctly bill your medical insurance. If we do not receive your insurance information your student account will be billed.