Insurance Information

Please return the following information with a copy of both the front and back of your medical insurance card within 14 DAYS.

Mail:

Watkins Health Services
Business Office
1200 Schwegler Drive
Lawrence, KS 66045

Fax:

Watkins Health Services
Attn: Business Office
Fax: 785-812-0213
Phone: 785-864-9520

Email:

whsbo@ku.edu

Please note:
While Watkins Health Services allows this form to be submitted electronically, the security of emailed health information cannot be guaranteed.

Patient Information

Place label here or write in if unavailable

Name _____
(printed)

KUID# _____ Date of Birth: _____

Patient Billing Address _____

City _____ State _____ Zip Code _____

Policy Information

Insurance Company Name _____

Insurance Company Address _____

City _____ State _____ Zip Code _____

Does your insurance have a specific lab requirement?
☐ NO ☐ Do not know ☐ YES — Please specify Lab name: _____

Member ID# _____ Group # _____

Policyholder Name _____

Policyholder Date of Birth _____ Relationship* _____ ☐ Male ☐ Female
(*Typically your Parent, Guardian or "Self")

Policyholder Street Address _____

City _____ State _____ Zip Code _____

First date of service to be billed _____ (Date of any prior services you would like billed to your Insurance)

— PLEASE NOTE —

1. You must contact your insurance company directly to determine how your specific plan processes and pays for services rendered at Watkins Health Services.
2. **Insurance referral** – If your insurance company requires pre-approval for services at Watkins Health Services, it is YOUR responsibility to provide that approval PRIOR to chargeable services being rendered. Unapproved charges will be YOUR responsibility.
3. We DO NOT accept Medicare, Medicaid plans or plans underwritten by health insurance companies based outside of the United States.