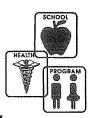


Family Health Network of Central New York, Inc



FAMILY HEALTH NETWORK OF CNY-SCHOOL HEALTH PROGRAM * INSURANCE/DATA FORM

Student name	SSN:	Date of l	Birth	
Address	City/Town		Zip Code	
Home Telephone # ()	_ Alternate Telephone (e	.g. cell) # ()	
Emergency Contact Person	C	ontact's Telephone	e # ()	
Emergency contact's relationship to student				
Does student have any allergies? Yes N	No If yes, to what?			
Allergic reaction (hives, itching, swelling, etc.)				
Who is the student's designated Primary Care Pro-	vider?	Telep	ohone # (_)
Address				
This question is strictly confidential and is asked f Student's Race: White Black			n Other	
^^^^^				^^^^^
INSURANCE INF	ORMATION – PLEASE CO	OMPLETE BOTH	H PARTS	
PART 1 - IF THE STUDE	NT HAS MEDICAID, PLEA	SE COMPLETE	THIS SECTION	ON
Identification number from card (i.e.: AB12345C))			
			olete the incura	nce section below)
Does the student have other medical insurance cov				
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INS	SURANCE INFORMATION	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~		
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INS	SURANCE INFORMATION ge?	I – PART 2	~~~~~~~	·······
INS Does the student have health insurance coverag If yes, name and address of insurance carrier:	SURANCE INFORMATION ge?	I – PART 2		
INS Does the student have health insurance coverage If yes, name and address of insurance carrier: Insured's ID#	SURANCE INFORMATION ge?	I – PART 2		
INS Does the student have health insurance coverage If yes, name and address of insurance carrier: Insured's ID# Insured's Name (person carrying coverage)	SURANCE INFORMATION ge?	T – PART 2 _ Relationship to S	Student	
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INS Does the student have health insurance coverage If yes, name and address of insurance carrier: Insured's ID# Insured's Name (person carrying coverage) Insured's Date of Birth Insured's Address (if different from student)	SURANCE INFORMATION ge?	_ Relationship to S	Student State	
INS Does the student have health insurance coverage If yes, name and address of insurance carrier: Insured's ID# Insured's Name (person carrying coverage) Insured's Date of Birth Insured's Address (if different from student)	SURANCE INFORMATION ge?	Relationship to S	StudentState	Zip
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INS Does the student have health insurance coverage If yes, name and address of insurance carrier: Insured's ID# Insured's Name (person carrying coverage) Insured's Date of Birth Insured's Address (if different from student) Complete this Secondary Insurance Information:	SURANCE INFORMATION ge?	_ Relationship to S ty Secondary Insura	Student State ^^^^^^^^^^^^^^^	Zip
INS Does the student have health insurance coverage If yes, name and address of insurance carrier: Insured's ID# Insured's Name (person carrying coverage) Insured's Date of Birth Insured's Address (if different from student) Complete this Secondary Insurance Information: Is this student covered by another insurance? Billing address of company Insured's ID#	SURANCE INFORMATION ge?	Relationship to S Secondary Insura	StudentState	
INS Does the student have health insurance coverage If yes, name and address of insurance carrier: Insured's ID# Insured's Name (person carrying coverage) Insured's Date of Birth Insured's Address (if different from student) Complete this Secondary Insurance Information: Is this student covered by another insurance?	SURANCE INFORMATION ge?	Relationship to S Secondary Insura	StudentState	
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Please complete reverse side

	under 19 years of age. This progra		ILD HEALTH PLUS. This program is available cial to your family. Would you like to receive more
If your family does not have heal Exchange. Would you like information	-	istance with enroll Yes	olling you in health insurance through the Health
PLEASE READ AND SIGN: I authorize the release of any medic FAMILY HEALTH NETWORK C	* *	s billing to the desi	signated insurance carrier and made payable to
SIGNATURE	RELATIONSH	IIP TO STUDENT	TT DATE

PLEASE NOTE: If your insurance company remits payment directly to you for services, it is your responsibility to forward this payment to FAMILY HEALTH NETWORK OF CNY, INC., 85 South West Street, Homer, NY 13077. Failure to remit this payment is insurance fraud.